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**A Product of the CMS Alliance to Modernize Healthcare
Federally Funded Research and Development Center
Centers for Medicare & Medicaid Services (CMS)**

Prepared For:

U.S. Department of Veterans Affairs

At the Request of:

Veterans Access, Choice, and Accountability Act of 2014

Section 201: Independent Assessment of the Health Care Delivery
Systems and Management Processes of the Department of Veterans
Affairs

Assessment L (Leadership)

September 1, 2015

Prepared for CAMH under:

Prime Contract No. HHS-M500-2012-00008I

Prime Task Order No. VA118A14F0373

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Preface

Congress enacted and President Obama signed into law the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146) (“Veterans Choice Act”), as amended by the Department of Veterans Affairs (VA) Expiring Authorities Act of 2014 (Public Law 113-175), to improve access to timely, high-quality health care for Veterans. Under “Title II – Health Care Administrative Matters,” Section 201 calls for an Independent Assessment of 12 areas of VA’s health care delivery systems and management processes.

VA engaged the Institute of Medicine of the National Academies to prepare an assessment of access standards and engaged the Centers for Medicare & Medicaid Services (CMS) Alliance to Modernize Healthcare (CAMH)¹ to serve as the program integrator and as primary developer of the remaining 11 Veterans Choice Act independent assessments. CAMH subcontracted with Grant Thornton, McKinsey & Company, and the RAND Corporation to conduct 10 independent assessments as specified in Section 201, with MITRE conducting the 11th assessment. Drawing on the results of the 12 assessments, CAMH also produced the Integrated Report in this volume, which contains key findings and recommendations. CAMH is furnishing the complete set of reports to the Secretary of Veterans Affairs, the Committee on Veterans’ Affairs of the Senate, the Committee on Veterans’ Affairs of the House of Representatives, and the Commission on Care.

The research addressed in this report was conducted by McKinsey & Company, Inc., under a subcontract with The MITRE Corporation.

¹ The CMS Alliance to Modernize Healthcare (CAMH), sponsored by the Centers for Medicare & Medicaid Services (CMS), is a federally funded research and development center (FFRDC) operated by The MITRE Corporation, a not-for-profit company chartered to work in the public interest. For additional information, see the CMS Alliance to Modernize Healthcare (CAMH) website (<http://www.mitre.org/centers/cms-alliances-to-modernize-healthcare/who-we-are/the-camh-difference>).

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Executive Summary

Scope

Part L (“Assessment L”), Section 201 of the Veterans Access, Choice, and Accountability Act of 2014 (“The Veterans Choice Act”) required an independent assessment of how leadership influences the Veterans Health Administration’s (VHA’s) ability to accomplish its mission. The law required an assessment of:

“(L) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.”

Congress has thus directed that VHA leadership be viewed in the context of the eight separate but related elements of leadership, each of which is addressed in detail in the assessment, as summarized below.

The broad scope of the law’s mandate represented an important opportunity to understand leadership at VHA, including its executive organization, Medical Center facility leaders, and regional network administrators. The scope of this assessment focuses on the senior leadership of VHA at each VA Medical Center (VAMC), Veterans Integrated Service Network (VISN), VA Central Office (VACO), and VHA Central Office (VHACO). The senior leadership at the VAMC and VISN are defined as the “Quadrad” or “Pentad” leaders: Director, Associate Director, Chief of Staff, Associate Director for Patient Care Services, and Assistant Director for Operations, if applicable.²

The assessment utilizes a three-step methodology entailing:

- (i) Data collection and analysis, including 39 site visits and more than 300 interviews with VHA leaders across the country, a survey of VHA employees about VHA leadership beliefs and practices, and analysis of existing VHA and other federal data;
- (ii) Synthesis of analyses, findings, and recommendations across the eight elements to identify patterns, points of interaction, and interdependencies. Through this process we identified overall findings and overarching recommendations; and
- (iii) Validation and testing to ensure a comprehensive mapping of findings and recommendations, as well as review by a Blue Ribbon Panel of outside experts and by subject matter experts (SMEs) from MITRE and McKinsey who did not participate in conducting the assessment.

Findings

Reviewing all eight elements described in Section 201, Assessment L provides an opportunity to create an integrated perspective of leadership at VHA. The scale of VHA is vast, and it is difficult to fully capture all the nuances and variability that exist throughout the system. Areas of

² The terms Quadrad and Pentad are used interchangeably throughout this report as they are at VHA.

excellence exist across the system, including some inspiring and resilient leaders, front-line systems redesign teams, and homegrown innovation. We touch on these throughout the full report. However, most areas of the organization show a highly risk-averse culture; lack of role clarity; fragmentation and organizational silos; and breakdowns in communication, accountability, and key processes that impair the organization's ability to deliver the mission.

Our efforts have yielded a complex portrait of leadership practices reflecting leaders at VHA who are diverse in their approach, experience, skill, and effectiveness. They are operating in a system without common agreed upon leadership goals, methods and processes. Examining each of the eight elements, we identified the following seven themes about leadership today at VHA:

- 1. An expanding scope of VHA activities has led to confusion around leadership priorities and the strategic direction of VHA.** The organization's focus has expanded and shifted over time, and it is unclear what the priorities are, and unclear when they will shift again. Over time, VHA has expanded into the delivery of a wide range of clinical services, as well as various social pursuits. The organization is not configured or resourced to deliver this expanding scope of activities, and it is unclear where the boundaries of the mission lie. VHA is also treated by oversight entities and external stakeholders as both a hospital system and a traditional government agency. This unique complexity of VHA is not supported by equally unique performance expectations, operational flexibility, and supporting tools.
- 2. From the point of view of leaders and employees, the VHA organization is intensely, unnecessarily complex due to lack of a clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities.** This lack of clarity around operating model, roles and responsibilities extends across VAMCs, the VISNs, and Central Office. The issue is exacerbated by a cultural context that is often unable to work effectively across chains of command, except where all parties concur. Fragmentation and silos exist across the system and within each tier of the organization. Many key support functions, such as human resources or contracting, suffer from this, resulting in service too slow to meet the needs of the mission. Meanwhile, the sheer number of operational performance measures in many cases overwhelms and makes it difficult to know and focus on what is most important.
- 3. The broader VHA culture is characterized by risk-aversion and distrust, resulting in an inability to improve performance consistently and fully across the system.** At almost every facility visited, at least one leader interviewed mentioned that risk-aversion and a reluctance to "speak up" were significant issues. Three out of every four leaders interviewed at VISNs in which site visits were conducted echoed this concern (VHA interviews, 2015). A general aversion to speak up or take risks originates from: a) trying to perform in a heavily siloed organization; b) fear that raising issues will result in punitive actions toward the individual or addition of significant workload with no additional support; and c) insufficient reward for those trying to make improvements. This culture permeates across all levels of the organization – from the front-lines, to Medical Center leaders, to people at Central Office. This culture of risk aversion also

hinders great ideas from spreading. A lack of enterprise-wide incentives and mechanisms for knowledge-sharing within or across the system yields pockets of innovation but not broader system-wide adoption (VHA interviews, 2015; VHA OHI survey, 2015).

4. **VHA leadership faces a workforce that appears to be steadily losing its motivation. Caring for Veterans is a value that powerfully motivates VHA leaders and employees alike – however, this commitment alone is insufficient to fuel the organization’s motivation and performance.** Other sources of motivation such as a great work environment, job satisfaction, or working with an inspiring team have eroded in recent years (VHA interviews, 2015). Physicians are only partially aligned with the various demands put on them. In a changing environment in which VHA competes with other health care organizations for top talent, a value proposition that relies primarily on the intrinsic reward of caring for Veterans cannot make up for the erosion of other sources of employee motivation to meet the VHA mission.
5. **The performance of a particular VAMC hinges to a large degree on the capability of its Director and the executive leadership team; yet these leaders are “on their own” in many ways.** VAMC Directors often lack competent and timely assistance from support functions (including HR for disciplining, hiring employees, planning for succession; construction; IT; and contracting). Support from VISN and VHACO is variable and often limited. Directors are left to navigate their own career progression and development (VHA interviews, 2015).
6. **VHA leadership attention is consumed by addressing crises that have occurred in the past, at the expense of preparing for tomorrow’s opportunities.** The number of directives for which leaders are accountable, coupled with heightened scrutiny from internal and external sources, compels leaders to spend much of their time reacting to crises and completing action items from above. Bottom-up innovation and consultative leadership are not well-developed, and there is a heavy reliance on top-down directives, exacerbated by the growth of Central Office Program Offices (VHA OHI survey, 2015; VHA interviews, 2015).
7. **The leadership pipeline is not robust enough to meet VHA’s current and future needs, a function both of inadequate succession planning and unfocused leadership development efforts.** As of March 2015, 16 percent of VAMC Quadrad and VISN Network Director positions are vacant or have acting leaders. Twenty-three VA Medical Centers (16 percent) do not have a permanent Director. Nine VISN Network Directors (43 percent) are Acting (VHA Office of Workforce Services, 2015). Leadership positions are increasingly unattractive to the next generation of VHA leaders, which contributes to the difficulty in filling leadership openings (VHA interviews, 2015). VHA is currently experiencing a large and widespread number of current vacancies and upcoming retirements in key leadership roles, and open positions remain unfilled due to a lack of qualified candidates. Meanwhile, VHA’s lack of a comprehensive approach to leadership development – experiential, relational, and training – has resulted in leaders with uneven preparation for their future roles. Multiple competency models and frameworks

are in use, and VHA's formal programs are not linked to career paths, not well-coordinated, and thus do not effectively bolster VHA's talent pipelines (VHA Office of Workforce Services, 2015; VHA interviews, 2015).

This report's findings indicate that immediate action is required. The challenges of the current culture and operating environment, the deteriorating atmosphere for leaders, and the intense public scrutiny suggest that sustaining an effective operation and an engaged employee and leadership base to serve six million Veteran enrollees each year will require a fundamental shift achieved through a bold, integrated, multi-year transformation.

Recommendations

The scale of the transformation needed to address the findings above has few precedents in the private or public sector. VHA employs one in nine federal civilian employees (OPM, Historical Federal Workforce Tables and FedScope, 2015). It is both the largest hospital system and the largest training ground for health care providers in the country, training tens of thousands of clinicians each year (VA, Office of Academic Affiliations, 2015). And the nature of the current system – with hundreds of unique locations, partnerships, and performance measures – only increases the complexity of the opportunity.

Given this challenge, the recommendations summarized below should not be approached like a checklist of individual and incremental performance improvements. Most transformations treated in this manner fail (Keller and Price, 2011). Instead, VHA should systematically implement these recommendations in a comprehensive, multi-year transformation program. The transformation program needs to clearly define its aspiration state, determine what is needed to meet this state, be housed in a formal change program, protect or build on best practices and high performing pockets, and ensure timely implementation faithful to the original aspiration.

Detailed recommendations are found in Section 4. These recommendations fall into six main opportunities:

1. Galvanize VHA leaders around a clear strategic direction.

Decide and communicate the strategic direction of VHA going forward. The strategy could take a variety of forms, but there needs to be clarity within VHA of where the organization is headed, and this needs to be communicated throughout the organization and understood by all leaders and employees. We do not seek to define the strategic direction here, but clear strategic direction will be critical as the organization moves forward and works to implement the recommendations laid out herein.

2. Stabilize, grow, and empower leaders.

VHA should strengthen its leadership foundation, both today's and tomorrow's. VHA should focus in the near term on increasing leadership stability and readiness by filling vacancies with high-quality leaders, improving the attractiveness of the role to prospective leaders, and ensuring leaders are ready to assume their roles. In the medium term they should build a coordinated people development strategy that connects top performers with the right opportunities and generates a robust pipeline of

leaders through a formal succession planning program and a coordinated set of development opportunities. Efforts should be made to build sustained leadership continuity across the system, including considering longer tenures for key leaders, such as Medical Center Directors and select roles at VHACO. This is necessary to have the authority, accountability, ownership and time needed to stabilize the organization, strengthen its health and performance, and shepherd the transformation.

3. Redesign VHA's operating model to create clarity for decision-making authority, prioritization, and long-term support.

VHA should immediately lead an effort to clearly define roles and decision rights at each level and increase coordination within Central Office, refocusing the role of Central Office to managing outcomes and providing "corporate center"-like support to the field. The Central Office should prioritize, integrate, and actively provide support to the various initiatives and policies being implemented by the field. The net effect of the redesign should be a Central Office that is highly valued by the field for the expertise, services, and strategic direction it provides.

4. Focus and simplify performance management to clarify accountability and actively support the mission.

Within six months, VHA should complete an effort to develop an integrated and balanced performance scorecard for VAMCs focusing on a smaller number of core metrics that roll up to support the broader enterprise view. These metrics should be designed to focus more on the mission and encourage cross-functional collaboration and should be carefully cascaded. This requires moving from hundreds today (over 382 alone in the National Performance Measures Report) to no more than 20 that cover quality, safety, patient experience, operational efficiency, finance, and human resources. The resulting data should be made readily available and accessible agency-wide with proper procedures in place to ensure quality.

5. Rebuild a high-performing, healthy culture by cultivating greater employee collaboration, ownership, and accountability to accomplish the mission.

Culture is often described simply as "how things are done around here," and changing the VHA culture will need to happen at all levels of VHA: VHACO, VISN, and the VAMC level, as well as within the context of VA broadly. VHACO should consider how to integrate their efforts so the workforce is involved and experiences a coherent set of messages, policies, and support from VHACO. The VISNs should lead the VAMC leaders by sharing best practices, demanding steady improvement, and encouraging innovation. VAMC leaders will need to role model the change, describe why the culture must change, reinforce desired behaviors (and discourage unhelpful ones), and provide leaders and employees alike with the coaching, training and tools they will need to succeed. In our experience this is feasible, but there is no simple or fast way, and it will require a dedicated performance transformation effort.

6. Redesign the human resources function as a more responsive customer service-focused entity.

VHA, with the full support and backing of VA, should begin an effort in the next 12 months to transform the human resources (HR) function to be more responsive to meeting the needs of VAMC leadership, more efficient, and more customer service-focused. Although a comprehensive examination of HR was not within scope of Assessment L, systematic HR challenges were identified that need to be addressed through a transformation of the HR function. Such a transformation will likely require redesigning key processes (e.g., hiring), shifting the mindsets of HR cadre from compliance to effectiveness, training HR and its customers on key roles and responsibilities, and rationalizing its technology systems.

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The views, opinions, and/or findings contained in this report are those of the assessment team and should not be construed as an official government position, policy, or decision.

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1 Introduction

1.1 Background

Title II Section 201 of the Veterans Choice Act requires an independent assessment of how VHA leadership impacts VHA’s ability to accomplish its mission. Specifically, the section requires an assessment of the competency of leadership with respect to eight elements: culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.

Table 1-1. Veterans Choice Act, Section L

Veterans Choice Act Section 201 (L)	Assessment L Section
Assess “the competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.”	<p>The report explores each element articulated in the legislation in a separate section of this report, as follows:</p> <ul style="list-style-type: none"> ▪ Section 5: Succession Planning ▪ Section 6: Leadership Development ▪ Section 7: Culture ▪ Section 8: Employee Engagement ▪ Section 9: Physician Alignment ▪ Section 10: Accountability ▪ Section 11: Performance Management ▪ Section 12: Reform Readiness <p>The topics are grouped according to three broad categories:</p> <ul style="list-style-type: none"> ▪ Leaders (Sections 5-6) ▪ Culture (Sections 7-9) ▪ Systems (Sections 10-12)

1.2 Scope

The scope of this assessment focuses on the senior leadership of VHA at each VA Medical Center (VAMC), network (VISN), and Central Offices (VACO, VHACO). The senior leadership at the VAMC and VISN are defined as the “Quadrad” or “Pentad” leaders and include the following (titles vary):

- Medical Center Director, Network Director
- Associate Director, Deputy Director
- Chief of Staff, Chief Medical Officer
- Associate Director for Patient Care Services, Chief Nursing Officer, Quality Management Officer

- Assistant Director for Operations (if applicable)

The terms Quadrad and Pentad are used interchangeably throughout this report as they are at VHA. This assessment looked only at leaders, not at the entire workforce.

1.3 Report Structure

This report is structured into three major sections: Assessment overview, Sub-assessment areas, and Enablers. The Assessment Overview (Sections 2-4) describes the methodology, the overall findings, and a holistic set of recommendations and implementation considerations. The next major section provides supporting evidence to the Assessment overview. This major section contains each of the sub-assessment areas or elements (Sections 5-12) with specific findings for each of the areas required by the Veterans Choice Act. Lastly, the Enabler section contains findings that are not in the sub-assessments required by the Act, but are nonetheless crucial to understanding leadership at VHA. Like the sub-assessment areas, the Enabler section provides supporting evidence for the overall Findings and Recommendations. Figure 1-1 provides a visual depiction of this structure.

Figure 1-1. Assessment Structure

Assessment structure

	Topic	Section
Assessment overview	Methodology	2
	Overall findings	3
	Recommendations and implementation considerations	4
Sub-assessment areas	Succession planning	5
	Leadership development	6
	Culture	7
	Employee engagement	8
	Physician alignment	9
	Accountability	10
	Performance management	11
	Reform readiness	12
Enabler	Supporting infrastructure	13

2 Methodology

2.1 Introduction

This independent assessment used a three-step methodology.

Step 1 – Data collection and analysis. The team drew on four primary data sources: site visit interviews (across 26 VAMCs, 13 VISNs, and selected VHACO and VACO leadership, for a total of 39 site visits and more than 300 interviews); surveys including a leadership survey across the entire VHA called the Organizational Health Index (OHI)[™] survey, the VA All Employee Survey (AES), and the Federal Employee Viewpoint Survey (FEVS); collection of primary source data where needed; and a review of past assessments and reports on VHA leadership.

Concurrently, the team defined each of the eight elements, reviewed and analyzed the data for each analysis, and validated the outcomes where possible with multiple sources (e.g., site interviews, OHI survey results, and primary data). We also developed a set of key questions around each element that formed the backbone of our Assessment L interviews. The key questions for each element are laid out **Appendix Table A-1**. The distribution of interviews conducted is presented in **Appendix Table A-2**.

Step 2 – Synthesis. In this step, we used the specific analyses to identify common findings and recurring themes. Using the analyses as the foundation, we identified the major findings within each of the eight leadership elements that most impact VHA’s ability to achieve its mission, and developed a set of detailed recommendations to address the findings. We then looked holistically at the findings and recommendations to identify patterns, points of interaction, and interdependencies. Through this process we identified seven overall findings and six overall recommendations.

Step 3 – Validation and testing. In this step, we mapped our overall findings and overall recommendations to ensure comprehensive coverage (see Appendix A for additional detail). We also asked multiple experts to review the analysis and findings in order to identify any bias, errors, or omissions. The primary review was conducted by the Blue Ribbon Panel (described in the Integrated Report). Additional reviews were conducted by subject-matter experts from both McKinsey and MITRE. Due to the required independence of the Veterans Choice Act, Section 201 assessments, findings and recommendations were developed independently. We therefore expect these recommendations will need to be refined by VHA leadership and the Commission on Care.

2.2 VAMC Site Selection

Stratified random sampling was used to select a core set of VAMCs for on-site assessment. This set of 23 VAMCs was representative of the VAMC system as a whole across critical facility demographic and performance outcome metrics (see Appendix A for further detail). In addition, the Assessment L team visited three additional VAMCs that had had major incidents to ensure a comprehensive view. The Assessment L team also visited 13 of the 21 VISN headquarters, as the

VISN leadership is seen as an important part of the chain of command that significantly impacts VAMC leadership.

2.3 Data Sources and Analysis

Data used in this report comes from four major sources: interviews, survey data, primary source data, and past assessments and reports.

Interviews. The team conducted over 300 interviews. These include approximately 224 interviews at VAMCs, 46 interviews at VISNs, 30 interviews with Central Office, and approximately 10 interviews of other federal agencies and former VHA leaders who are now in the private sector. At each VAMC site, we sought to interview the Director, Deputy Director, Chief of Staff, Associate Director for Patient Care Services/Chief Nurse Executive, Assistant Director for Operations, Union representative, as well as additional personnel, time allowing (e.g., Nurse Manager, Service Chief, HR Administrator). We conducted interviews at 13 of the VISNs, focusing on interviewing the Director, Deputy Director, and others as available (e.g., Chief Medical Officer).

Throughout this report, we draw heavily from these interviews. In selecting quotations to share, we worked to find quotations that are representative and illustrative of the themes and patterns that we heard throughout the interviews.

Survey data. This assessment used the VA All Employee Survey (AES), the Federal Employee Viewpoint Survey (FEVS), and the Organizational Health Index (OHI)TM survey. The AES and FEVS are government-conducted surveys focused on employee satisfaction, and we used the results from 2014 surveys. The FEVS is administered annually by Office of Personnel Management (OPM) and is a sample survey across federal agencies. The AES is administered annually by VA and is a census survey of VA employees.

The OHI survey examines current organizational strengths and weaknesses, with a special emphasis on leadership practices. This tool has been used across leading health care institutions and other government agencies. The OHI survey was used to assess the leadership practices at VHA in order to show how they contribute to the organization's health and performance. The OHI does not measure employee satisfaction (which is covered in other survey instruments such as FEVS and AES).

The OHI survey was selected as one of the key inputs for this assessment, because of its large data set (used for benchmarking) and statistical reliability and validity. Beginning collection in 2003, the OHI data set currently has over 700 organizations and 1.3 million respondents, and includes both 27 public sector and 33 health provider organizations. Using the global set of organizations across multiple industries a strong correlation exists between organizational health and organizational performance (De Smet, Palmer, & Schaninger, 2007). At its essence organizational health enables organizations to maintain the highest levels of financial and operating results (Keller and Price, 2011). For example, public companies with "top quartile" organizational health had a 68 percent chance of achieving above-average EBITDA margins, compared to the 31 percent likelihood of companies in the bottom quartile of health. Similar

relationships between performance and health also exist at business-unit levels within organizations (Leslie, Loch & Schaninger, 2006).

Within VHA, the participation was $n=13,712$, with a response rate of roughly five percent. For this response rate, the OHI standard calculates margin of error at the 95 percent confidence level, which means that there is a 95 percent probability that the results of the complete population are within the margins of error of the results obtained. It is a standard used across the industry. The average margin of error was VHA: ± 0.82 percent.

From a statistical basis, the OHI has tested as both reliable and valid.

- Reliability refers to the consistency of a survey measurement. An evaluation instrument is reliable when it produces consistent, although not necessarily identical, results. A widely accepted measure of reliability is Cronbach's coefficient alpha – an intercorrelation coefficient of survey items to evaluate its internal consistency. All the OHI alpha scores are within the ideal range (0.76 at the lowest for the talent practice and 0.91 at the highest for the Coordination and Control outcome).
- The validity of a survey refers to whether the survey can really measure what it intends to measure. Factor analysis is one of the most common methods to test the validity of a survey (Tabachnick & Fidell, 2001). The factor loadings for all the outcome items are close to or higher than the $+0.50$ desired range (0.53 at the lowest for Reward and Recognition practice and 0.87 at the highest for Meaningful Value practice).

Throughout the report, VHA is compared to the OHI global benchmark, as well as a public sector benchmark and a health care benchmark. The public sector benchmark comprises 27 surveys ($n=47,159$), and the Health Care Systems and Services benchmark comprises 33 surveys ($n=40,437$). The global benchmark includes all organizations in the OHI database. Additional detail on the OHI and its results are located in Appendix A.

Primary source data. In order to complete several of the analyses, we used primary source data from VHA and other sources. The specific source for each analysis is listed with the specific analysis. Example data used include: VA AES results; FEVS; leadership vacancy rates; employee performance ratings; performance reports including Strategic Analytics for Improvement and Learning (SAIL); and employment and separation data from both VHA and the Office of Personnel Management. It should be noted that we did not conduct an audit to validate the accuracy of data were provided, although, where applicable, we did note potential data integrity issues highlighted during site visit interviews.

Most data requested were received within three months of request. In some cases, requested data could not be provided because VHA personnel reported that the data did not exist, or did not exist in an internal consolidated data tracking system. Examples of this included leadership development budgets for all programs and performance ratings for non-executive employees. This limited our ability to make detailed data-driven observations on some elements of leadership development and performance management; where possible, desired analyses were replaced by interviews and other sources of data.

Past assessments and reports. The Assessment L team conducted a thorough review of eight recent VHA assessments and reports. These reports were conducted by the Office of Inspector

General (OIG), Government Accountability Office (GAO), and other third-parties that investigated leadership topics, either directly or indirectly. These reports were used to provide context for Assessment L; however, all analyses in this report are based on primary source data. See Appendix A for the complete list of reports reviewed.

We also reviewed documents that govern or inform current activities taking place at VHA, such as the VA Strategic Plan, the VHA Strategic Plan, and the Blueprint for Excellence (VA, FY2014-2020 Strategic Plan, 2014; VHA, 2014 Interim Workforce and Succession Strategic Plan 2014; VHA, Blueprint for Excellence, 2014). Recognizing that many of the efforts described in these documents are currently underway, it is too early to comment in detail on them, but the recommendations contained herein in some cases are well-aligned with the efforts currently in progress.

3 Overall Findings

3.1 Overall Findings

Reviewing all eight elements described in Section 201, Assessment L provides an opportunity to create an integrated perspective of leadership at VHA. The scale of VHA is vast, and it is difficult to fully capture all the nuances and variability that exist throughout the system. Areas of excellence exist across the system, including some inspiring and resilient leaders, front-line systems redesign teams, and homegrown innovation. We touch on these throughout the full report. However, most areas of the organization show a highly risk-averse culture; lack of role clarity; fragmentation and organizational silos; and breakdowns in communication, accountability, and key processes that impair the organization's ability to deliver the mission.

Our efforts have yielded a complex portrait of leadership practices reflecting leaders at VHA who are diverse in their approach, experience, skill, and effectiveness. They are operating in a system without common agreed upon leadership goals, methods and processes. Examining each of the eight elements, we identified the following seven themes about leadership today at VHA:

- 1. An expanding scope of VHA activities has led to confusion around leadership priorities and the strategic direction of VHA.** The organization's focus has expanded and shifted over time, and it is unclear what the priorities are, and unclear when they will shift again. Over time, VHA has expanded into the delivery of a wide range of clinical services, as well as various social pursuits. The organization is not configured or resourced to deliver this expanding scope of activities, and it is unclear where the boundaries of the mission lie. VHA is also treated by oversight entities and external stakeholders as both a hospital system and a traditional government agency. This unique complexity of VHA is not supported by equally unique performance expectations, operational flexibility, and supporting tools.
- 2. From the point of view of leaders and employees, the VHA organization is intensely, unnecessarily complex due to lack of a clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities.** This lack of clarity around operating model, roles and responsibilities extends across VAMCs, the VISNs, and Central Office. The issue is exacerbated by a cultural context that is often unable to work effectively across chains of command, except where all parties concur. Fragmentation and silos exist across the system and within each tier of the organization. Many key support functions, such as human resources or contracting, suffer from this, resulting in service too slow to meet the needs of the mission. Meanwhile, the sheer number of operational performance measures in many cases overwhelms and makes it difficult to know and focus on what is most important.
- 3. The broader VHA culture is characterized by risk-aversion and distrust, resulting in an inability to improve performance consistently and fully across the system.** At almost every facility visited, at least one leader interviewed mentioned that risk-aversion and a reluctance to "speak up" were significant issues. Three out of every four leaders

interviewed at VISNs in which site visits were conducted echoed this concern (VHA interviews, 2015). A general aversion to speak up or take risks originates from: a) trying to perform in a heavily siloed organization; b) fear that raising issues will result in punitive actions toward the individual or addition of significant workload with no additional support; and c) insufficient reward for those trying to make improvements. This culture permeates across all levels of the organization – from the front-lines, to Medical Center leaders, to people at VHACO. This culture of risk aversion also hinders great ideas from spreading. A lack of enterprise-wide incentives and mechanisms for knowledge-sharing within or across the system yields pockets of innovation but not broader system-wide adoption (VHA interviews, 2015; VHA OHI survey, 2015).

4. **VHA leadership faces a workforce that appears to be steadily losing its motivation. Caring for Veterans is a value that powerfully motivates VHA leaders and employees alike – however, this commitment alone is insufficient to fuel the organization’s motivation and performance.** Other sources of motivation such as a great work environment, job satisfaction, or working with an inspiring team have eroded in recent years (VHA interviews, 2015). Physicians are only partially aligned with the various demands put on them. In a changing environment in which VHA competes with other health care organizations for top talent, a value proposition that relies primarily on the intrinsic reward of caring for Veterans cannot make up for the erosion of other sources of employee motivation to meet the VHA mission.
5. **The performance of a particular VAMC hinges to a large degree on the capability of its Director and the executive leadership team; yet these leaders are “on their own” in many ways.** VAMC Directors often lack competent and timely assistance from support functions (including HR for disciplining, hiring employees, planning for succession; construction; IT; and contracting). Support from VISN and VHACO is variable and often limited. Directors are left to navigate their own career progression and development (VHA interviews, 2015).
6. **VHA leadership attention is consumed by addressing crises that have occurred in the past, at the expense of preparing for tomorrow’s opportunities.** The number of directives for which leaders are accountable, coupled with heightened scrutiny from internal and external sources, compels leaders to spend much of their time reacting to crises and completing action items from above. Bottom-up innovation and consultative leadership are not well-developed, and there is a heavy reliance on top-down directives, exacerbated by the growth of Central Office Program Offices (VHA OHI survey, 2015; VHA interviews, 2015).
7. **The leadership pipeline is not robust enough to meet VHA’s current and future needs, a function both of inadequate succession planning and unfocused leadership development efforts.** As of March 2015, 16 percent of VAMC Quadrad and VISN Network Director positions are vacant or have acting leaders. Twenty-three VA Medical Centers (16 percent) do not have a permanent Director. Nine VISN Network Directors (43 percent) are Acting (VHA Office of Workforce Services, 2015). Leadership positions are increasingly unattractive to the next generation of VHA leaders, which contributes

to the difficulty in filling leadership openings (VHA interviews, 2015). VHA is currently experiencing a large and widespread number of current vacancies and upcoming retirements in key leadership roles, and open positions remain unfilled due to a lack of qualified candidates. Meanwhile, VHA's lack of a comprehensive approach to leadership development – experiential, relational, and training – has resulted in leaders with uneven preparation for their future roles. Multiple competency models and frameworks are in use, and VHA's formal programs are not linked to career paths, not well-coordinated, and thus do not effectively bolster VHA's talent pipelines (VHA Office of Workforce Services, 2015, VHA interviews, 2015).

3.2 Prioritizing the Eight Elements

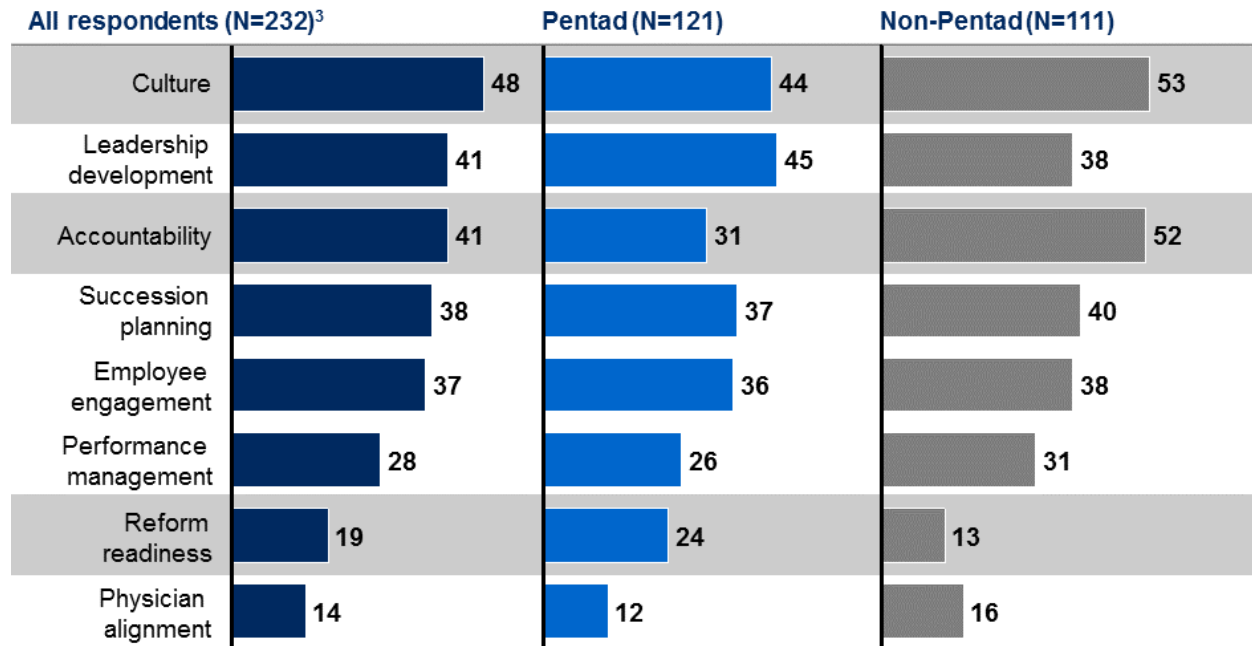
Over the course of the site visits, leaders were presented a list of the eight leadership elements (culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management). They were then asked which three of the eight leadership elements, if improved, would most benefit the VHA mission. VHA leaders most frequently identified culture, leadership development, and accountability as elements that, if improved, would have the greatest opportunity to help advance VHA. Succession planning and employee engagement followed closely in priority. Physician alignment, reform readiness, and performance management were viewed as the lowest on the list of priorities. **Figure 3-1** shows this prioritization.

Figure 3-1. Top Three Leadership Priorities

VHA prioritization of leadership elements

Percent of responses mentioning element as Top 3 opportunity area

■ All respondents
 ■ Pentad¹
 ■ Non-pentad²
 ■ Largest differences between pentad and non-pentad



¹ Pentad includes senior leaders at VAMCs and VISNs

² Non-pentad includes all others, including VHACO leadership

³ Not all interviews included this question

SOURCE: VHA interviews, 2015, in response to the question: "Going back to our 8 elements, which three, if improved, have the best chance of advancing VHA's mission?"

These preferences were consistent across Pentad and non-Pentad leadership with three exceptions: culture, accountability, and reform readiness. Non-Pentad leaders mentioned culture and accountability each more than 50 percent of the time, while Pentad leaders mentioned them 44 percent and 31 percent, respectively. And reform readiness, though lower on the priority list, is much more top-of-mind for Pentad leaders (24 percent) than non-Pentad leaders (13 percent).

4 Recommendations and Implementation Considerations

4.1 Introduction

This report's findings indicate that immediate action is required. The challenges of the current culture and operating environment, the deteriorating atmosphere for leaders, and the intense public scrutiny suggest that sustaining an effective operation and an engaged employee and leadership base to serve six million Veterans each year will require a fundamental shift achieved through a bold, integrated, multi-year transformation.

These detailed recommendations were developed to address the findings presented in this report. As explained in the methodology section, we looked holistically at the findings and recommendations to identify patterns, points of interaction, and interdependencies, and through this process we identified six overarching recommendations that encompass the detailed recommendations:

1. Galvanize VHA leaders around a clear strategic direction.
2. Stabilize, grow, and empower leaders.
3. Redesign VHA's operating model to create clarity for decision-making authority, prioritization, and long-term support.
4. Focus and simplify performance management to clarify accountability, actively support the mission, and promote continuous improvement.
5. Rebuild a high-performing, healthy culture by cultivating greater employee collaboration, ownership, and accountability to accomplish the mission.
6. Redesign the human resources function as a more responsive customer service-focused entity.

The impact to the Veteran of such changes will be immediate, significant, and long lasting. Immediately, the recommendations focus on improving the care given to Veterans by providing stable, empowered, and prepared leaders. Significantly, the recommendations put the Veteran forefront in the behaviors and mindsets of VHA employees by changing from individual or functional performance to focusing on the delivery of care. Lastly, the recommendations create a long-term, sustainable culture focused on ownership of the mission, innovation, and clear accountability.

The scale of the transformation needed to address the findings above has few precedents in the private or public sector. VHA employs one in nine federal civilian employees (OPM, Historical Federal Workforce Tables and FedScope, 2015). It is both the largest hospital system and the largest training ground for health care providers in the country, training tens of thousands of clinicians each year (VA, Office of Academic Affiliations, 2015). And the nature of the current system – with hundreds of unique locations, partnerships, and performance measures – only increases the complexity of the opportunity.

Given this challenge, the recommendations summarized below should not be approached like a checklist of individual and incremental performance improvements. Most transformations treated in this manner fail (Keller and Price, 2011). Instead, VHA should systematically implement these recommendations in a comprehensive, multi-year transformation program. The transformation program needs to clearly define its aspiration state, determine what is needed to meet this state, be housed in a formal change program, protect or build on best practices and high performing pockets, and ensure timely implementation faithful to the original aspiration.

This requires capable leaders, dedicated resources in a central transformation management office, relaxation of constraints to accelerate the effort (e.g., reducing non-statutory constraints), careful monitoring and management, and consistent senior management attention and focus over the life of the effort. Success will require VHA leaders to role model the change needed, describe why the transformation is needed, reinforce desired behavior, and provide leaders and employees alike with the coaching, training and tools they need. This will require a sequenced approach, designed to stabilize leadership, strengthen the organizational foundation, and sustain performance.

Details on the approach to recommendation development may be found in Appendix A.

4.2 Recommendations

4.2.1 Galvanize VHA Leaders Around a Clear Strategic Direction

As a backdrop to this transformation, VHA should clearly define its strategic direction, articulating what VHA is working toward. This can set a well-defined foundation for the changes that will be implemented. Specifically:

- Decide and communicate the strategic direction of VHA going forward. The strategy could take a variety of forms, but there needs to be clarity within VHA of where the organization is headed, and this needs to be communicated throughout the organization and understood by all leaders and employees. We do not seek to define strategic direction here, but clear strategic direction will be critical as the organization moves forward and works to implement the recommendations laid out herein.
- Determine activities and priorities based on clarified strategic direction through a full review of existing activities and decisions to stop, start, modify, or continue as appropriate. The outcome of this should be complete alignment and integration of activities and priorities against this strategic direction, across all levels of the organization (VAMC, VISN, VHACO, VACO). Congressional approval may be required to change some of the VHA priorities, in particular stopping or starting some of the VHA activities.

4.2.2 Stabilize, Grow, and Empower Leaders

VHA should strengthen its leadership foundation, both today's and tomorrow's. VHA should focus in the near term on increasing leadership stability and readiness by filling vacancies with high-quality leaders, improving the attractiveness of the role to prospective leaders, and

ensuring leaders are ready to assume their roles. In the medium term they should build a coordinated people development strategy that connects top performers with the right opportunities and generates a robust pipeline of leaders through a formal succession planning program and a coordinated set of leadership development opportunities.

4.2.2.1 Jumpstart the Transformation and Increase Leadership Stability and Readiness in the Next Six to Twelve Months

The three steps below are intended to immediately address the vacancy issue that impacts nearly four in 10 Medical Centers and ensure every location in VHA has an established local leadership team in place to lead the transformation (VHA Office of Workforce Services, 2015). This will help to stabilize the system while a broader and more robust leadership pipeline is developed and implemented.

- Fill current and planned leadership vacancies at Medical Centers and VISNs quickly, through internal promotions for those who are prepared and ready for the positions, retention, signing or relocation incentives, and external hires with extensive health system management experience. The intent here is to get the “right” people, with the “right” preparation, into these positions swiftly. This will require aggressive and expedited recruitment, hiring, and on-boarding processes, for both internal and external hires. For internal hires, this may mean offering a qualified Acting leader a 2-year Interim position, or expediting candidates that are already in the process. High-caliber external candidates should be considered for remaining vacancies. As one VHACO leader explained, “while it’s not a long-term answer, we need to look at exploiting other mechanisms to address our hiring needs – for example, other agencies get around this with 2-year appointments.” To fill these positions swiftly and help stabilize the system, VA should designate a lead senior executive to drive the Senior Executive Service (SES)³ hiring process on behalf of the VISNs/VAMCs and gain OPM approvals, place more authority with the VISN to expedite non-SES hiring, and consider using external recruiters for this initial surge of hiring. VHA should focus on the VISN Network Director and Medical Center Director positions immediately, who can then take leadership in filling other pivotal Pentad roles. This recruiting effort should be led by the VISNs to streamline approvals and expedite the process. VHA should consider relaxing the hiring freeze for other select VISN positions (the hiring freeze does not impact Medical Centers). While recruiting and development are listed as a key transformational action in the Blueprint for Excellence, as of May 2015 VHA does not show any actions related to recruiting, and assesses their efforts at “potential risk (yellow)” (VHA, Blueprint for Excellence, 2014).
- Strengthen the appeal of the role for senior leaders by pursuing regulatory or legislative changes that expand or create a new federal classification for VHA Pentad leaders and other critically needed/vacant positions, combining the flexibility that exists in other federal positions (e.g., Title 38⁴, SES, Excepted Service) to address compensation and

³ Senior Executive Service (SES) employees constitute the senior executives throughout federal government.

⁴ Title 38 is a federal classification for health care professionals and covers a range of clinical professions at VHA.

benefits, hiring decisions, promotion process, and performance management. This will create a balance that enhances the system's ability to reward senior leaders for the risk they assume in this increasingly politicized environment, while also making it easier to usher poor performers out of the system. It should be noted that VA is pursuing a legislative remedy in its most recent federal budget request to expand Title 38 salary flexibility to non-clinical leadership positions, although Congress has yet to act on this request (VA, 2016 Congressional Submission, 2015).

- Prepare VHA leaders through an executive development program that would use formal (e.g., training) and informal (e.g., mentorship) methods when they begin new roles. The focus should be two-fold: what leaders need to know within the first six months of taking on a senior leadership role (e.g., Congressional process, budgeting, and labor management), and introduction to a network of colleagues outside of their facility. Responsibility for successful execution of these programs should be placed with VISN directors. Some VISNs and the national New Executive Training Program (NExT)⁵ have strong on-boarding programs, though they often happen irregularly, meaning leaders may not get to them until a year or more after they have been in their new role. Codifying the best of these and making them available across the system would help leaders be better prepared for the additional responsibilities accompanying their new role (e.g., hiring, budgeting, interaction with labor, significant public duties). On-boarding sessions should be held as needed, likely at least monthly, and new senior leaders should attend, either in their VISN or a neighboring VISN, within the first month of assuming a senior leadership role. Ongoing mentoring and support should also occur. An SES coaching program currently exists, with 75% of new SES appointees matching with a coach in 2014, and 96% matched in 2013, though usage and effectiveness of the coaching program is unclear and highly irregular (VHA Healthcare Talent Management Office, 2015; VHA interviews, 2015).

4.2.2.2 Establish a People Development Strategy That Creates a Pipeline of Future Leaders and Greater Leadership Continuity

- Create a succession management process across VHA that connects individuals with the leadership pipeline. VHA should replace the current system of unwritten rules and ad hoc decisions with a formal candidate identification, preparation, and placement program that is regularly reviewed by VHA leadership (VHA interviews, 2015). This should be done in a way that is consistent with the Merit System Principles (5 USC, Section 2301), or policy changes should be sought to change or grant temporary exceptions to these principles. Fundamentally, VHA should establish a way to track individual candidates over time across the system, ensure they are provided the right leadership development opportunities at the right times, and match them to the right career opportunities throughout the system.

⁵ VHA Office of Workforce Services, "Healthcare Talent Management Workforce Development Programs within the Veterans Health Administration," 2014.

- Rationalize leadership development offerings. Focusing on critical leadership needs, maintain or reintroduce successful programs from the past (as has begun with the relaunch of Health Care Leadership Development Program, or HCLDP), and build new programs as needed. Eliminate existing programs that are duplicative, or have not demonstrated an ability to create a pipeline of future leaders (e.g., program graduates do not ascend to positions for which the program is designed to deliver). Move to a career path model that connects leadership candidates to a suite of appropriate opportunities (learning, networking, mentoring, coaching, apprenticeship, and career experience) at the right time in their development, with ownership of the career path elements housed in a centralized office. Ensure that those with potential and interest are applying to programs. Establish leadership development program selection criteria that are determined by succession need and employee performance and potential.
- Construct a single, comprehensive VHA competency model for leaders throughout the system that reflects the latest needs of health care executives and forms the foundation for future development, preferably leveraging the existing competing frameworks.
- Build sustained leadership continuity, including considering longer tenures for key leaders, to have the authority, accountability, ownership and time needed to stabilize the organization, strengthen its health and performance, and shepherd the transformation. As part of this, VHA could consider:
 - Declaring the intent for Medical Center Directors to have a four-year minimum tenure with the objective to remain in place for six to eight years and with the understanding that exceptions are necessary but should not be the norm. The purpose of this recommendation is to increase organizational stability and continuity at the facility level by ensuring each leader is present long enough to build a rapport with the facility and its leadership team, and see significant efforts through to completion or sustainable implementation. Additionally, it reduces the frequency of geographic displacement, a dynamic that is becoming increasingly unattractive to many facility leaders (VHA interviews, 2015). As VHA develops leadership career paths, it could consider adapting this recommendation by Medical Center complexity level, recognizing the importance of the “feeder system” offered by smaller facilities.
 - Increasing leadership stability and resilience in political headwinds by lengthening tenure of key political appointees, to enhance continuity and span administrations. Key leaders would therefore be considered for a term akin to the IRS⁶ commissioner given the apolitical nature of their role and the challenging circumstances of this transformation. With the IRS, for example, Congress authorized the U.S. Internal Revenue Service Reform and Restructuring Act of 1998 (RRA 98). The RRA 98 allowed Charles Rossotti a five-year term that crossed the Clinton and G.W. Bush administrations, and provided Rossotti the opportunity to fully implement the IRS transformation (Rainey and Thompson, 2006).

⁶ Internal Revenue Service

- Remove or reduce non-statutory constraints (e.g., travel restrictions, inadequate assessment of candidates, tying training to relocation) that limit effective delivery of career development opportunities.

4.2.3 Redesign VHA's Operating Model to Create Clarity for Decision-Making Authority, Prioritization, and Long-Term Support

VHA should immediately lead an effort to clearly define roles and decision rights at each level and increase coordination within Central Office, refocusing the role of Central Office to manage outcomes and provide “corporate center”-like support to the field. The Central Office should prioritize, integrate, and actively provide support to the various initiatives and policies being implemented by the field. The net effect of the redesign should be a Central Office that is highly valued by the field for the expertise, services, and strategic direction it provides. To attain that goal, VHA should consider the following specific recommendations:

- Clarify the roles and responsibilities of each major operating unit – VHACO, the VISNs, VAMCs, CBOCs⁷, and other organizational units. Clarify decision rights of the VISN and Medical Center.
 - Articulate decision rights clearly by level, organization, and role, standardizing where appropriate while also allowing for regional flexibility based on local needs.
 - Clearly define the role of the VISN (or any other regional structures being considered), including defining key roles and responsibilities, the balance between empowerment and support of medical facilities, and their role in coordinating, translating, communicating, and innovating across the system. Such an approach would be consistent with the simplicity of purpose of the VISNs when they were created in the mid-1990s. The role of the VISN should focus on the following:
 - Promoting continuous improvement across the VISNs and within their respective networks
 - Ensuring effective coordination and collaboration across sites (between and across VAMCs and CBOCs, as well as non-VA care). Examples include:
 - Creating local forums for best practice sharing across sites
 - Creating work groups around service lines that require regional coordination (such as stroke, cardiovascular) – where reaching certain volumes is correlated with higher quality, or where only certain centers will offer a given service such as with coronary artery bypass surgery (CABG), transplant, etc. These should be aligned against and collaborate closely with VHACO's “lines of business” (discussed in further detail below).
 - Coordinating contracting, network management and other elements of non-VA care within region

⁷ Community-based outpatient clinic.

- Setting performance improvement agenda for each VAMC in partnership with VAMC Director and creating transparency across the VISN on performance
- Prioritizing capital investments across the VISN
- Succession planning and participation in hiring/firing decisions on VAMC Directors and potentially other top team staff
- Acting as a communication channel to and from VACO, translating field needs and concerns up, and VACO direction, requests, and decisions down. It is critical for the VISN/region to have some discretion and help orchestrate or prioritize among what is coming “down from corporate,” especially while there is not good coordination centrally. This role would become more minor as Central Office requests and directives become streamlined.
- Formally define thresholds for Medical Center Pentad decision-making approval (e.g., amount of budget, hiring, policy latitude before approval is required).
- Reorganize VHACO around an enterprise view designed to support the field, increasing collaboration, supporting prioritization, ensuring alignment with strategic direction. The intent of this is to move from a series of “stove-piped” program offices issuing independent directives and action items, with few mechanisms to encourage coordination, to a much smaller number of coordinated primary strategic priorities. These could be organized similarly to how a private sector health system might organize its corporate center in “lines of business,” around which supporting program offices would be organized and through which supporting program office work would be conducted. Such “lines of business” would coordinate and support regional work groups (as described above). This would create a system that can flex and be more agile as new priorities are identified by Congress or VA.
 - In service of this, VHA should rationalize current program office activity through a comprehensive review that is designed to reshape program offices to meet the following set of criteria:
 - Designed to develop and champion key clinical priorities, processes, and best practices that are directly supporting the mission and strategic direction of VHA
 - Collaborative and holistic, focusing on critical processes and outcomes rather than individual directives
 - Aggregated into a small number of well-coordinated offices and initiatives to minimize contradictory guidance and directives
 - Coordinated centrally, with the requisite resources available to the field
 - Proactive and strategic, with “lines of business” that stand the test of time and are not primarily reactive
 - Reviewed periodically with a broader enterprise view (i.e., not in isolation), with a clear mechanism to sunset offices that are no longer needed
 - Establish a regular, periodic time (e.g., quarterly, semi-annually) when process guidance is released to Medical Centers for acceptance or modification, and finalized. This will help create a forum for greater coordination between program offices and

enable greater continuity in the field due to less frequent interruptions by new directives.

- Create policy communication standards that require any new policy to include a clear rationale, a recommended approach, an expectation of a local implementation plan, and sufficient time to implement a local plan. This would be one of the responsibilities of the new lines of business.
 - Require alignment between and coordination across policy (10P) and operations (10N), by actively eliminating the “artificial distinction between policy and ops” that exists today (VHA interviews, 2015). This could include, for example, ensuring that all guidance issued to the field is thoroughly reviewed, approved, and prioritized by operations before being released by VHACO. The reviews should ensure the policies are feasible to implement, have the necessary resources to execute, and a proper feedback mechanism to indicate whether the field is able to successfully act on guidance.
- Return to more flexible funding:

As discussed in the findings (see Section 13.2), we believe the size and fragmentation of earmarked funds (e.g., 450 separate specific line items) has eroded the ability to manage toward an outcome for Medical Centers. Congressional action will likely be required to change the designated (earmarked) funds. While we are suggesting greater flexibility, that does not imply less oversight, as managing to the overall budget will remain a critical leadership responsibility.

- Evaluate current funding model and reduce number of special programs, or bundle specific purpose funding, to ensure Medical Centers have local flexibility to shift resources appropriately. Request the necessary Congressional authorization approval.
- Ensure VISNs have adequate authority to shift resources appropriately as needed. Ensure the Veterans Equitable Resource Allocation (VERA) model sufficiently accounts for anticipated demographic and geographic shifts. The new model should be revised to function effectively while still complying with Congressional restrictions.
- Conduct review of full set of financial management systems and streamline where appropriate to improve system interoperability. A better planning and resource management system is required. For example, one clear opportunity is to replace financial management, inventory, and procurement systems with a modern ERP system that allows full integration of supply chain processes with financial accounting (see Assessment J for additional detail).
- Bolster decision support and analytics. Improve the process to develop and approve staffing requests, including providing and supporting scalable, evidence-based staffing methodologies and interdisciplinary resource management processes for key employee populations. Ensure feedback loops are built into contracting and facilities processes.

4.2.4 Focus and Simplify Performance Management to Clarify Accountability, Actively Support the Mission, and Promote Continuous Improvement

Within six months, VHA should complete an effort to develop an integrated and balanced performance scorecard for VAMCs focusing on a smaller number of core metrics that roll up to support the broader enterprise view. These metrics should be designed to focus more on the mission and encourage cross-functional collaboration and should be carefully cascaded. This requires moving from hundreds today (over 382 alone in the National Performance Measures Report) to no more than 20 that cover quality, safety, patient experience, operational efficiency, finance, and human resources. The resulting data should be made readily available and accessible agency-wide with proper procedures in place to ensure quality. Specific recommendations include:

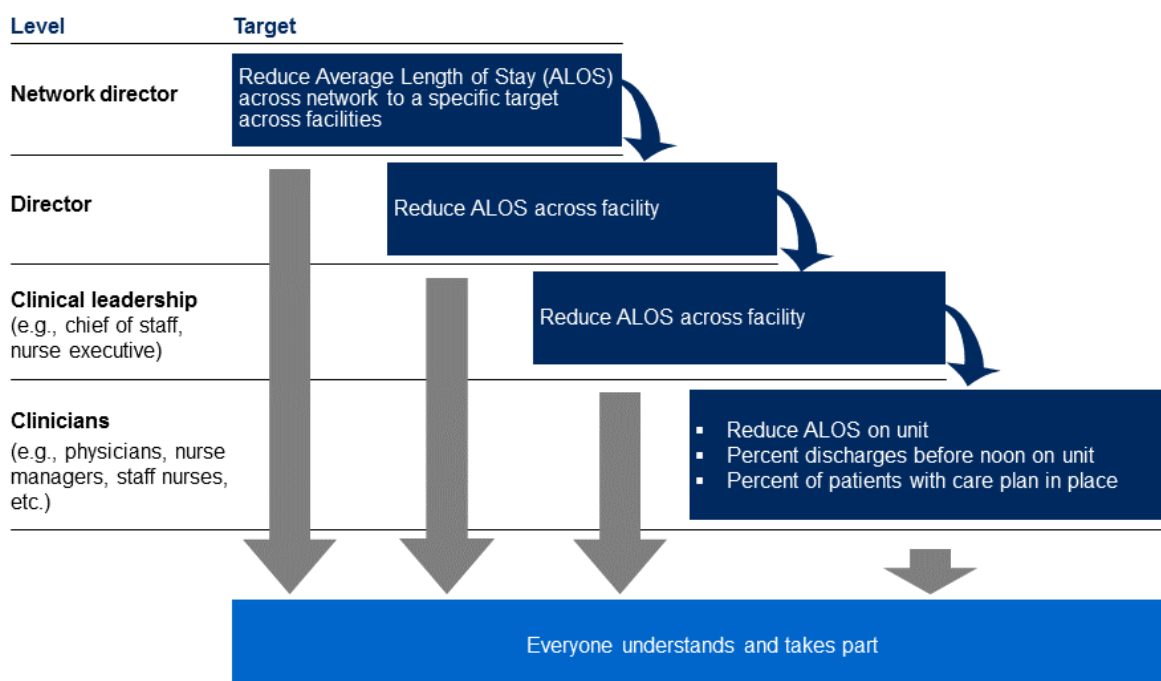
- Create an integrated and balanced performance scorecard for VAMCs. Specifically:
 - Reduce the total number of required key performance metrics from several hundred to no more than 20, covering domains including quality and safety, patient experience, operational efficiency, finance, and human resources. This should cascade from the Director's performance plan throughout the organization, resulting in not more than 10 to 20 metrics per position, rolling up to not more than 20 key metrics for the overall Medical Center. At each level, metrics should be precise and actionable.
 - Ensure core metrics remain consistent across facilities year-over-year to underpin operational excellence and continuous improvement around VHA's strategic priorities.
 - Reserve space for locally-determined priorities in addition to the core metrics across facilities, both to manage against local needs and to encourage ownership.
 - Communicate expectations before the start of a performance year, eliminating the frequent lengthy delays in communicating expectations to the facilities. Having a core set of metrics year-over-year would help mitigate any remaining delays, as facilities would already be familiar with the majority of the expectations.
 - Motivate employees through financial and non-financial incentives, including bonuses, potential for advancement, and other non-financial incentives. Examples include: 1) expanding individual recognition by Pentad leaders, with select use of spot awards; 2) communicating clear promotion paths; and 3) providing high-performing employees with access to training and exposure to regional and national leadership, for example, opportunities to present initiatives to senior leaders at their VISN or at VHACO.
- Design effective and motivating performance management through cascaded metrics linked to the enterprise goals, such as celebrating successes and linking metrics to incentives.
 - Assign ownership of key metrics across the organization such that employees clearly understand how their work contributes to performance against mission and strategic direction **[Figure 4-1]**.

- Develop performance measures that have a stronger emphasis on mission contribution and team outcomes. Base performance measurement on mission contribution for all employees (e.g., fewer individual functional metrics and more team- or facility-based metrics). This will incent collaborative behavior as teams have to work together to achieve outcomes. By encouraging more cross-functional cooperation, this could also decrease siloed thinking and fragmentation.
- Tie financial incentives for leaders, such as bonuses, to mission contribution in a significant way (e.g., mission contribution and individual performance are weighted equally in determining bonus amounts).

Figure 4-1. Cascading Metrics

Targets should cascade down, and should be precise and actionable at each level

ILLUSTRATIVE



- Increase facilities' ability to capture, access, and work with more real-time data to enhance transparency and help leaders manage for performance. This capability will support process improvement efforts by providing rapid feedback on the impact of changes so that facility leaders can identify, share, and build on their results. More real-time data can also improve transparency and the personal accountability by allowing individuals to see how they compare to their peers.
- Use performance management to promote continuous improvement.

- VHACO leaders should establish a limited number of forward-looking goals and targets to drive significant changes system-wide. These goals should focus on changes that can advance a critical few priority health outcomes and should be included as part of the balanced scorecard. These goals and targets should not be compliance-focused or overly prescriptive and should energize local innovation and improvement efforts throughout VHA. For these specific clinical conditions where data show there is a significant quality improvement opportunity, VHACO leaders should set bold but achievable targets for the system. An example of VHA's past success in advancing a critical health outcome is the reduction of hospital-acquired Methicillin-resistant *Staphylococcus aureus* (MRSA) infections throughout by 68 percent from 2007-2012, compared to the reduction in non-VHA hospitals of only 38 percent during that same period. VHA has shown that bold efforts on key goals can result in impressive health outcomes across the system (Evans et al., 2012).
- Facility leaders should champion the use of improvement techniques (for example, Business Process Redesign, Lean Six Sigma, visual management systems like huddleboards, etc.) to spur data-driven progress. These techniques increase ownership at the local level and engage the front-line employees, who are closest to the work, in developing solutions. Medical Center leaders must prioritize, support, and be actively engaged in these improvement efforts in order to create a sustained culture of collaborative problem-solving and improvement.
- VHA leaders should clarify decision-making processes, roles, and thresholds related to performance measures and emphasize their use to facilitate learning. When early indicators suggest an issue, offer coaching and consultation before punitive action. This requires a commitment of leaders at each level to initiate collaborative problem-solving and to use measures as a tool for progress rather than a management stick. All leaders will need to support and reinforce this message to create psychological safety for people to raise issues rather than obscure them.

4.2.5 Rebuild a High-Performing, Healthy Culture by Cultivating Greater Employee Collaboration, Ownership, and Accountability to Accomplish the Mission

Culture is often described simply as “how things are done around here,” and changing the VHA culture will need to happen at all levels of VHA: VHACO, VISN, and the VAMC level, as well as within the context of VA broadly. VHACO should consider how to integrate their efforts so the workforce is involved and experiences a coherent set of messages, policies, and support from VHACO. The VISNs should lead the VAMC leaders by sharing best practices, demanding steady improvement, and encouraging innovation. VAMC leaders will need to role model the change, describe why the culture must change, reinforce desired behaviors (and discourage unhelpful ones), and provide leaders and employees alike with the coaching, training and tools they will need to succeed. In our experience this is feasible, but there is no simple or fast way, and it will require a dedicated performance transformation effort. Specific recommendations include:

- Spur collaboration

- Introduce a more collaborative approach to cross-functional activities, replacing functional silos with employees working together across functions or services to advance the mission. Select specific functions or services that require multiple stakeholders, similar to the Patient Aligned Care Team (PACT) model to focus on. This is already occurring in some facilities and is ripe for scaling to other facilities and functions (e.g., hiring, contracting, specialty clinics). An open mindset on the part of leaders and employees alike would support this exploration of new ways of working together. More cross-functional dialogue, system redesign, and joint performance metrics would also help underpin this collaborative approach.
- Encourage innovation, both within and across facilities, and beyond the system
 - Celebrate risk-taking. Publically celebrate efforts to advance the mission and innovate – both successes and smart failures – through recognition events, staff communications, and informal interactions. This will at once engender a culture of appreciation and a psychologically-safe environment where appropriate risk-taking is not only accepted, but invited and celebrated. This may take some time, and there is an opportunity to signal commitment to this through some early actions and role-modeling.
 - Build processes, roles, and systems to scale best practices. Strengthen mechanisms to identify and scale best practices; this will likely need to be an individual's primary responsibility in each Medical Center. Pentad leaders should view this as a key responsibility of theirs as well. Other mechanisms could include knowledge-sharing forums or conferences (internal and external), systems designed to capture and disseminate ideas (for example, an "idea bank" around systems redesign), and incentives. This should also include more deliberate pursuit of opportunities for partnership beyond the system, such as relationships with academic medical centers or other government agencies.
- Foster a culture of continuous improvement, learning, and ownership
 - Harness the local knowledge, experience, and enthusiasm of front-line employees to drive lean process redesign. This is happening in many places today, in a variety of ways (Gemba, MESS Boards, SIM, and other visual management systems). This has to be driven, sponsored, and reinforced from VISN and VAMC leadership and cascade throughout the management chain. A spirit of learning and improvement must be encouraged (such as, "yes, let's try this"), and employees need to feel like they can take calculated risks and are "safe to fail" to readjust attitudes and behaviors. This should be reinforced with performance management.
 - Shift to a culture of ownership, supported by clarified decision rights and open communication. Introduce new communication strategies with employees that will help them both understand *why* measures are taken and influence *how* such measures are taken. For example, clinical directives should begin with a clearly articulated rationale explaining the purpose and the impact. Likewise, administrative directives or requests for data should explain their purpose and their intended outcome.

- Shift from an expectation that the front-line will simply implement policies, to an expectation that the front-line will be involved in pragmatic discussions of how to achieve intended outcomes. This increased communication and dialogue will increase employee engagement and meaningfully inform policy and directives. As local leadership draws employees into key decisions in a more deliberate and transparent way, in effect trusting them to become leaders of their system, this will engender more trust, and ultimately enhance ownership and psychological safety.
- Invite employees to the dialogue. Draw on the expertise of the workforce to improve local leadership decisions. Specifically: 1) create a rotating position where supervisors and front-line employees join select executive leadership meetings; 2) establish weekly executive office hours; and 3) increase the consistency of formal and informal dialogue with employees through labor-management partnerships, town halls, and daily rounds. This is being done in some facilities already, and there is an opportunity to spread this further.
- Connect to the strategic direction. Directly connect all employees' tasks with VHA's strategic direction to clearly identify their contributions. Specifically: 1) include how the activities performed by employees support the mission and strategic direction in all communications; 2) craft performance plans and position descriptions that increase emphasis on mission-related activities and decrease emphasis on compliance-related activities, with the intent of increasing role clarity; and 3) provide non-clinical employees with more opportunities to interact with Veterans.

It should be noted that getting people to listen, and motivated to act, is getting harder and harder. VHA may need an innovative leading-edge communication campaign, combined with substantially increased face-to-face interactions, to make messages “stick” in this environment. This input comes with responsibility, and needs to be underpinned by rigorous performance management and transparent data systems that ensure accountability.

4.2.6 Redesign the Human Resources Function as a More Responsive Customer Service-Focused Entity

VHA should begin an effort in the next 12 months to transform the human resources (HR) function to be more responsive to meeting the needs of VAMC leadership, more efficient, and more customer service-focused. Although a comprehensive examination of HR was not within scope of Assessment L, systematic HR challenges were identified that need to be addressed through a transformation of the HR function. Such a transformation will likely require redesigning key processes (e.g., hiring), shifting the mindsets of HR cadre from compliance to effectiveness, training HR and its customers on key roles and responsibilities, and rationalizing its technology systems. This will require detailed understanding of the regulatory environment and close collaboration with stakeholders including but not limited to unions and OPM.

Specific recommendations pertaining to HR include:

- Streamline or redesign processes so they include clear roles, responsibilities, service-level agreements, and performance metrics, all designed to help HR actively support VHA

leaders in a timely way and to help address compliance requirements (e.g., discipline process expectations, hiring process turnaround times, troubleshooting of federal regulations). For example, in many facilities, HR is urged to fill 80 percent of positions within 60 days. Several HR groups spoke of self-imposed constraints that lengthened hiring time for their internal customer: “to make sure we meet speed-of-hire, we’d turn back certs [hiring certificates] instead of extending them, if the services didn’t give us exactly what we needed. Now, we’re trying to encourage the team, rather than turn the cert back, to keep pushing to fill the role” (VHA interviews, 2015). By simplifying and redesigning the hiring process, VHA can design a more collaborative process that is at once more efficient and responsive to customers’ needs. Picking a few key processes, redesigning them locally, piloting them in a few sites, and then rolling out nationally is one way to advance this.

- Provide training and tools to all hiring managers on federal regulations related to key processes, for example, hiring or progressive discipline, so that all stakeholders understand the regulatory nuances to be able to keep the process moving as swiftly as possible. For example, ensure system leaders understand their role in driving the hiring process, and HR employees understand what is (and is not) required to keep processes moving effectively and efficiently. Though processes can sometimes be quite labor-intensive, they are clearly documented. Better knowledge of, training around, and adherence to process guidance – by HR and its customers alike – would enhance execution. Ensure process adherence is a focus of leaders as well.
- Remove functions from human resources that are more appropriately controlled elsewhere in the organization (for example, centralize responsibility for local physician recruiting with physician leadership at VISN, similar to private sector hospital systems).
- Rationalize human resources technology systems to decrease complexity and increase coordination among functions. One VAMC reported having more than 30 different HR systems and tools. Another HR leader explained, “Someone can call us for something as simple as written counseling, and before we can even give them any advice, we have to go into two or three systems to even know who they are” (VHA interviews, 2015). Rationalizing systems and increasing interoperability would enhance HR’s ability to serve its customers.

4.3 Implementation Considerations

As previously noted and in alignment with Section 201 of the Choice Act, Section 201 assessments, findings and recommendations were developed independently. We therefore expect these recommendations would be refined by VHA leadership and the Commission on Care.

Below, we have listed the changes that we believe are fundamental preconditions for successfully implementing the recommendations described in Section 4.2, as well as suggested immediate actions to be taken at the national level.

4.3.1 Pre-Conditions for Implementation

The transformation described in this assessment must take place within a system and culture that is currently in flux. As VHA seeks to stabilize itself, it must do so using some of the very tools, systems, and processes that are not working well today, in an environment where there may not yet be clarity of strategic direction, role clarity, and local empowerment. This dynamic should be kept in mind, especially regarding critical success factors around implementation.

Recognizing the interdependencies of this transformation effort, there are several pre-conditions for success:

- Clear definition of where the organization is headed, grounded in VHA’s mission and strategic direction, and a careful articulation and communication of the path to meet this aspiration
- Support and commitment from senior leadership in the field and in Central Office, bolstered by strong field involvement (including the front-line)
- Congressional support
- Capacity, perhaps created by scaling back or stopping select initiatives that are less important to strategic direction
- A formal change program housed in a central transformation office, with authority and resources designed to be able to support the transformation throughout the organization. This needs to include staff that can be deployed in the field to support facilities in design, implementation, and scaling of best practices
- A clear action plan, with milestones and timelines, to ensure timely implementation of the vision
- Demonstrated progress, early wins, and ongoing monitoring
- Sustained and consistent leadership

Throughout, VHA leaders will need to role model the change needed, describe why the transformation is needed, reinforce desired behaviors, and provide leaders and employees alike with the coaching, training, and tools they will need to succeed.

4.3.2 Immediate Actions for Consideration

Some efforts should be considered to begin right away, while others will likely require more advanced planning and resourcing before meaningful design or implementation can begin. Recommended immediate actions are laid out in **Table 4-1** and should include:

Table 4-1. Immediate Actions

Overall recommendation	Potential immediate actions
Galvanize VHA leaders around a clear strategic direction	<ul style="list-style-type: none"> ▪ Clarify strategic direction ▪ Directly communicate strategic direction to all employees throughout the organization

Assessment L (Leadership)

Overall recommendation	Potential immediate actions
Stabilize, grow, and empower leaders	<ul style="list-style-type: none">▪ Fill vacancies with the “right” leaders through internal and external hires
Redesign VHA’s operating model to create clarity for decision-making authority, prioritization, and long-term support	<ul style="list-style-type: none">▪ Align operating model with overall strategic direction▪ Consolidate VHACO into fewer and coordinated “lines of business”
Focus and simplify performance management	<ul style="list-style-type: none">▪ Develop an integrated and balanced scorecard for VAMCs, focusing on a small number of core metrics
Rebuild a high-performing, healthy culture by cultivating greater employee collaboration, ownership, and accountability to accomplish the mission	<ul style="list-style-type: none">▪ Connect employees’ tasks with overall strategic direction▪ Open lines of communication
Redesign the human resources function as a more responsive customer service-focused entity	<ul style="list-style-type: none">▪ Focus on advancing the mission versus compliance only

5 Succession Planning

5.1 Summary

This report defines succession planning as “the process of identifying long-range needs and cultivating a supply of internal talent to meet those future needs” (Society for Human Resource Management).

A well-functioning succession management process begins with identifying specific needs for critical positions and includes:

- Proactively identifying needs for key leadership positions
- Specifically identifying individual candidates
- Developing leaders
- Connecting candidates with the right openings at the right time.

In determining how well VHA’s succession planning approach meets its leadership pipeline needs, study findings are as follows:

- VHA is currently experiencing a large and widespread number of current vacancies and upcoming retirements in key leadership roles, and open positions remain unfilled due in part to a lack of qualified candidates.
- Leadership positions are increasingly unattractive to the next generation of VHA leaders, which contributes to the difficulty in filling leadership openings.
- The existing succession planning effort does not meet the needs of VHA.

Throughout this section, we draw on insights shared during interviews with VHA leaders as well as data from the OHI survey (VHA interviews, 2015; VHA OHI Survey, 2015). Unless otherwise cited, direct quotations are from VHA interviews and survey data are from the OHI survey. We also draw on various other primary source data and cite them as appropriate throughout the section.

5.2 Findings

5.2.1 VHA Is Currently Experiencing a Large and Widespread Number of Vacancies and Upcoming Retirements in Key Leadership Roles, and Open Positions Remain Unfilled Due in Part to a Lack of Qualified Candidates

In discussing succession planning at VHA, a Medical Center employee described a consistent theme: “We have been talking about the coming leadership crisis for 10 years, but we never did anything about it. Now we’re seeing it become a reality.”

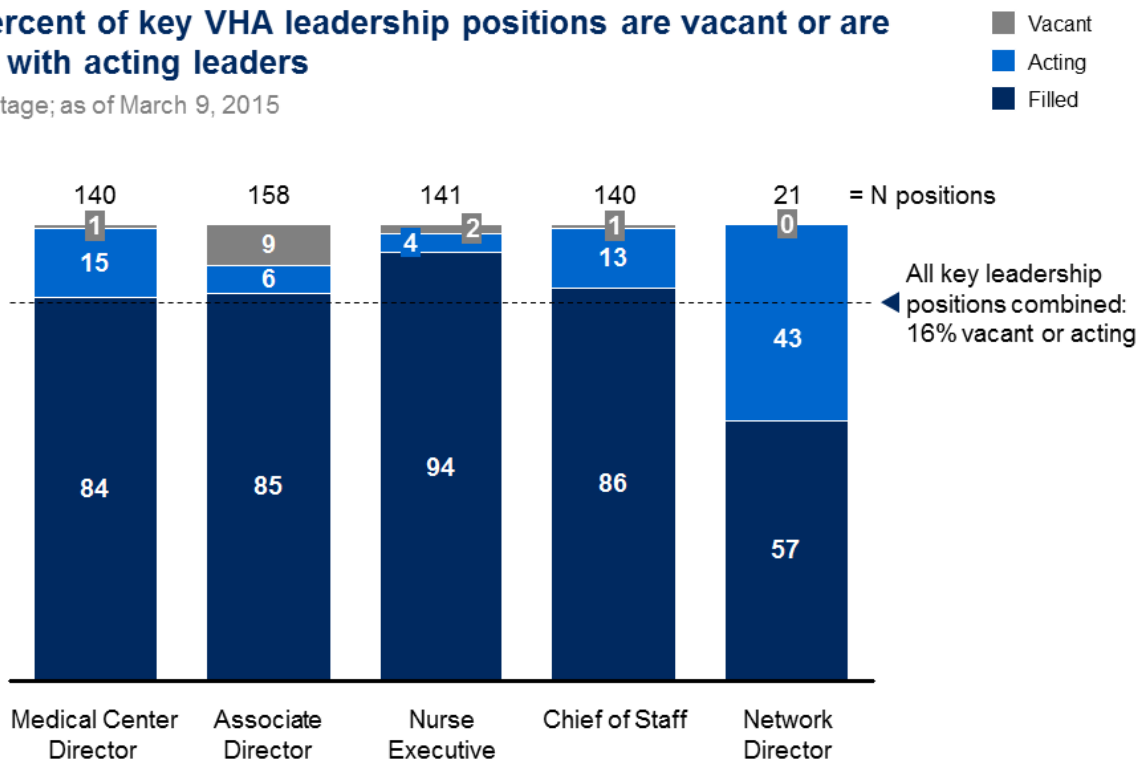
Figure 5-1 describes this reality. As of March 2015, 16 percent of VAMC Quadrad and VISN Network Director positions are vacant or have acting leaders (VHA Office of Workforce Services,

2015). Twenty-three VA Medical Centers (16 percent) do not have a permanent Director. Nine VISN Network Directors (43 percent) are Acting. In addition, this trend extends to the top of the organization as three of the top five officials at VHACO are Acting at the time of this assessment.⁸

Figure 5-1. Current Leadership Vacancies and Actings

16 percent of key VHA leadership positions are vacant or are filled with acting leaders

Percentage; as of March 9, 2015



SOURCE: VHA Office of Workforce Services, as of March 2015

This reality is also widespread across key leadership positions in Medical Centers: 39 percent of VAMC Quadrads have at least one current vacancy; three Medical Centers operate with only one permanent Quadrad member. Our interviews acknowledged that the vacancies were due in part to the VHACO and VISN hiring freeze, approvals of the VAMC and VISN positions at the VACO level, and anticipation of the VISN realignment. However, all leadership vacancies have downstream consequences throughout the chain of command. For example, where there are VISN Network Director vacancies, potential Medical Center Director applicants report a hesitancy to pursue positions where their direct supervisor is an unknown entity. As one Acting Director said, “This position has been open nearly a year and one of the main reasons people

⁸ The three Acting positions include: Acting Principal Deputy Under Secretary for Health, Acting Deputy Under Secretary for Health for Operations and Management (DUSHOM), and Acting Chief of Staff. The two permanent positions mentioned above are Under Secretary for Health and Deputy Under Secretary for Policy and Service.

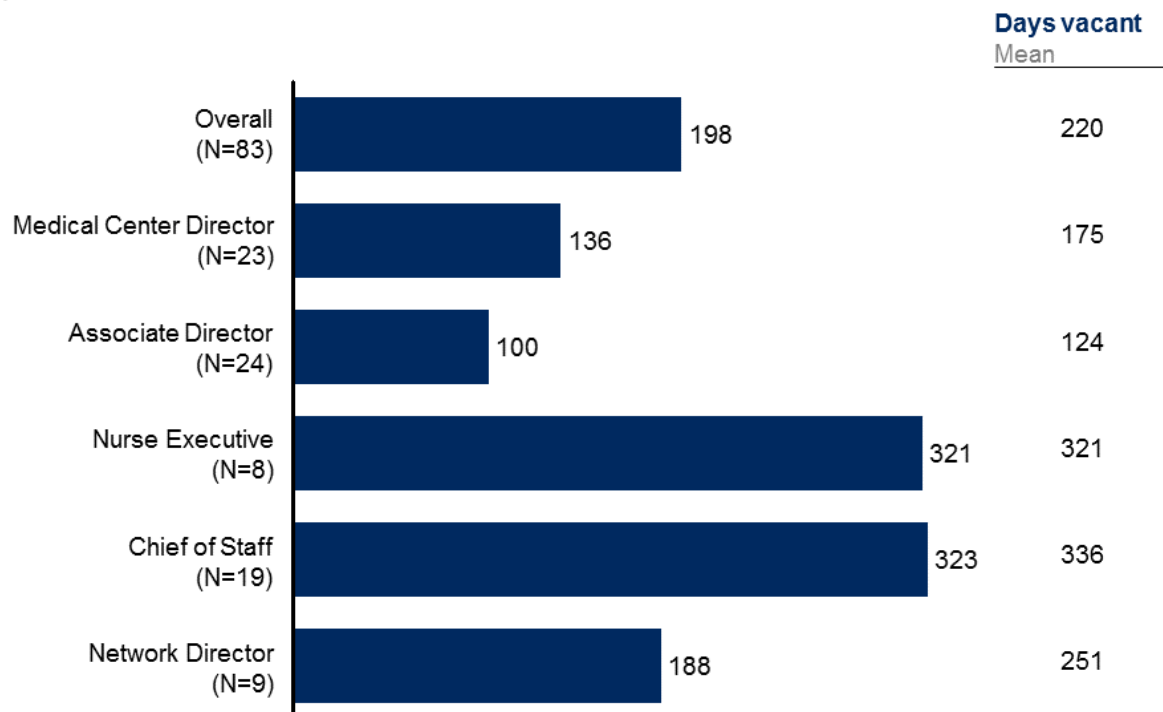
won't take it is that they haven't filled the Network Director yet – who would ever take a job without knowing whom you are working for?" Similar reluctance was expressed at other levels (e.g., Service Chief reporting to an Acting Chief of Staff). High retirement eligibility – 57 percent for key leadership positions, detailed in the next section – worsens this picture (VHA Office of Workforce Services, 2015).

Faced with significant key leadership vacancies and the potential for even larger ones in the months and years ahead, VHA has been unable to fill leadership gaps quickly. The length of time current key openings have been unfilled stretches for greater than seven months on average, with over half of all key openings currently open for greater than six months (VHA Office of Workforce Services, 2015) [Figure 5-2].

Figure 5-2. Length of Vacancies

Currently vacant key VHA leadership positions have been open for a median of 198 days

Days vacant, median



SOURCE: VHA Office of Workforce Services, as of March 2015

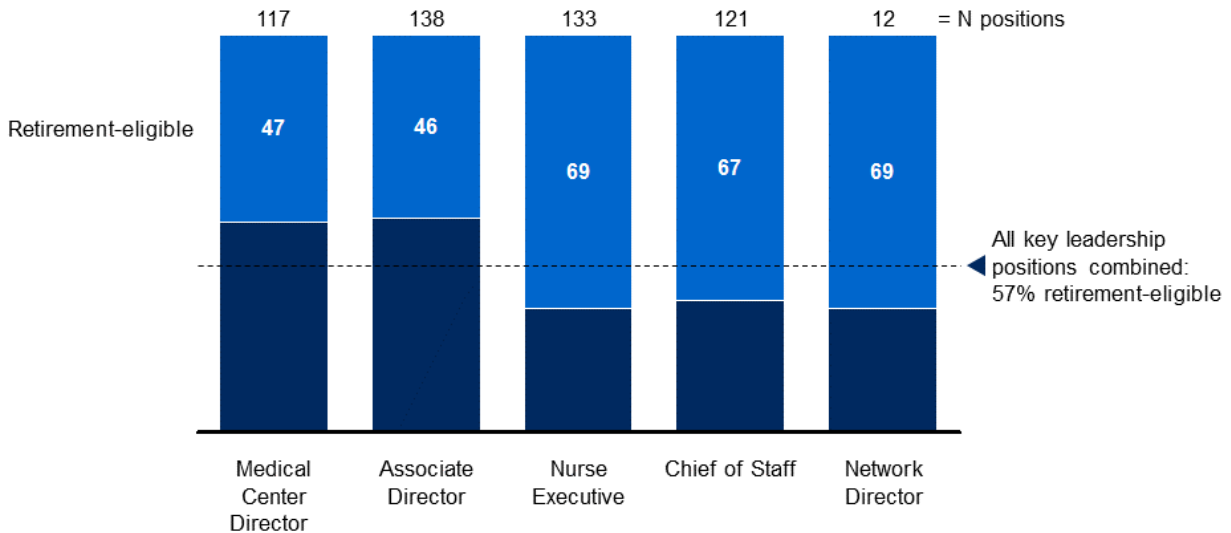
The current length of vacancy days is likely attributable to a lack of available candidates as well as the hiring process itself. This is validated by discussions at the VAMC and VISN levels, where interviewees report, "I'm starting the hiring process with just three viable resumes for a Medical Center Director position," and "We are probably hiring people too early on in their VA careers for these positions, but we don't have a choice. We're setting them up for failure."

A large retirement-eligible population among its current leaders threatens to deepen the leadership vacancy challenge faced by VHA. **Figure 5-3** shows that 57 percent of leaders in key positions are retirement-eligible.⁹ Over two-thirds of Network Directors, Nurse Executives, and Chiefs of Staff are retirement-eligible, as well as 47 percent of Medical Center Directors (VHA Office of Workforce Services, 2015). There are indications that this retirement threat is beginning to be realized; in FY 2014, retirements by VHA employees GS-13 and higher increased by 37 percent over the previous 5-year average (OPM, FedScope, accessed 2015).

Figure 5-3. Retirement Eligibility

57 percent of key filled VHA leadership positions are held by retirement-eligible leaders

Percentage; as of March 9, 2015



SOURCE: VHA Office of Workforce Services, 2015

⁹ “Key positions” are defined as VISN Network Director and Medical Center Quadrad leaders (Medical Center Director, Associate Director, Associate Director for Patient Care Services/Chief Nurse Executive, and Chief of Staff).

5.2.2 Leadership Positions Are Increasingly Unattractive to the Next Generation of VHA Leaders, Which Contributes to the Difficulty in Filling Leadership Openings

According to Office of Personnel Management (OPM) officials interviewed, applications to Senior Executive Service (SES) positions across the federal government have been stable in recent years (Office of Personnel Management interview, 2015). This suggests that VHA's struggles with filling senior positions are somewhat unique.

The VHA leadership value proposition for all leaders in VHA does not balance the intense pressure, scrutiny, and life changes required by the position. The value proposition is decreasing for the next generation – today's managers, supervisors, and team leaders. As **Figure 5-4** displays, just one in four managers and supervisors respond positively when asked about the attractiveness of career opportunities, as compared to one in three executives today. This is most pronounced when speaking with Pentad and VISN staff who could be considered candidates for Medical Center Director positions but are not pursuing advancement. This was also reflected in interviews: one in three Pentad leaders suggested there was little incentive to take a promotion as it substantially increased risk with little increase in potential reward. Risk in this context was defined as the potential consequences of increased exposure to the media, Congress, and VHACO in the current environment.

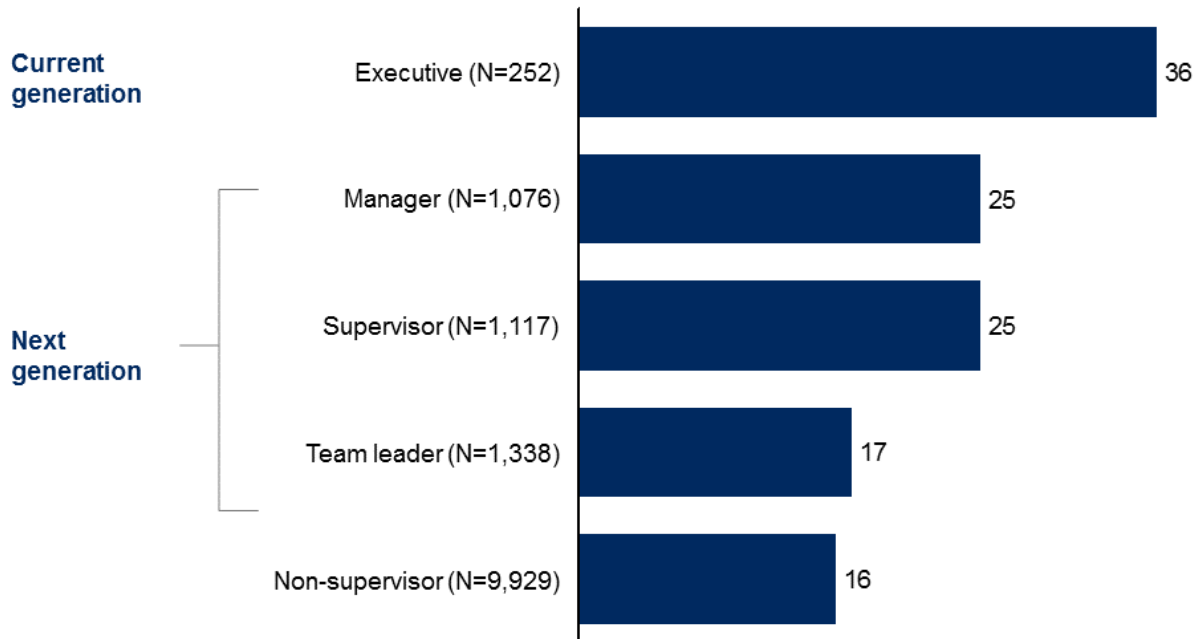
Figure 5-4. Career Opportunities

Next generation of VHA leaders considers career opportunities less attractive than current generation

Career Opportunities: Percent of respondents who frequently observe the following¹:

“The organization offers top performers the most attractive career opportunities within the organization”

“Promotions in the organization are based on merit”



¹ Score is generated based on average of responses to the two questions

SOURCE: VHA OHI Survey 2015 (N=13,712)

The unpredictable short-tenure assignments contribute to making these positions less attractive for the next generation of leaders. In many cases, this unpredictable nature is caused by frequent movement between positions due to reassignment or application for new positions. The resulting shorter tenures have a material impact on the leader’s ability to make change happen quickly – often the organization will “wait them out.” Employees appear more resistant to a career path that requires frequent geographic mobility. According to data provided by VHA, current SES employees have worked at four to five locations in their VHA career, with a 3- to 4-year average length of stay at each location (VHA Office of Workforce Services, 2015). As one Director said, “My team today isn’t willing to put their families through all the upheaval that I did to mine.” In addition, many Directors assume their roles toward the end of their careers, which requires the patience of navigating a gradual career progression with a single employer. Interviewees reported that this nature of progression was less accepted by the next generation of leaders.

5.2.3 The Existing Succession Planning Effort Does Not Meet the Needs of VHA

No key succession planning elements are fully practiced by VHA. Federal statute clearly lays out the succession planning responsibilities of agencies, which include:

- Development of a “comprehensive management succession program, based on the agency’s workforce succession plans, to fill agency supervisory and managerial positions”
- Succession efforts supported by agency training and mentoring: the focus “should be to develop managers as well as strengthen organizational capability”
- “Ensure an adequate number of well-prepared and qualified candidates for leadership” are available in the agency (U.S. Code Title 5 CFR Section 412).

What follows is a set of best practice elements of succession planning and management (Day, 2007; Society for Human Resource Management, “Successful Practices in Succession Planning”).

Figure 5-5 assesses VHA’s current practices rated against these best practice elements.





- **Proactively identifying needs for key leadership positions.** This involves senior leadership regularly meeting to review major leadership positions and the status of potential successors for each position. Today, VHA’s workforce planning process is an aggregation of bottom-up needs and is limited to detailing broad categories of priority occupations. For VHA, this proactive identification could happen at the VISN level, with input from VHACO as well.
- **Specifically identifying individual candidates.** Once specific needs are identified, successor candidates should be recommended by managers who are trained to evaluate for potential as well as performance. Today, VHA lacks both the tools (position management system, a candidate assessment center for specific development tracks) and processes (a potential component of the performance management process) to identify individual candidates.
- **Developing leaders.** Cultivation of leaders is addressed elsewhere in this report (see Section 6), but important to note here is that leadership development plans and programs should specifically grow succession-identified pipelines. Access to programs in VHA occurs “without a lot of rhyme or reason” according to one VHA official, and development plans, according to interviews with HR officials, are completed by employees on their own, without a formal mechanism for dialogue with their managers or other mentors. They may choose to consult with their managers in the process, but it is at their discretion.
- **Connecting candidates with the right openings at the right time.** Career paths to positions for those participating in development programs and activities should be predictable with clear expectations. At VHA, leadership development programs prepare candidates for positions that, for example, require mobility when that may not be of interest to the employee being trained. Additionally, a series of “unwritten rules” complicates the leadership path, with potential leaders perceiving that VHA favors, for example, facility complexity progression (gaining experience leading a Level 2 facility before leading a Level 1 facility) and certain experience needs (assignment details or VISN exposure) before approving a promotion to senior leadership (VHA interviews, 2015).

Figure 5-5. VHA Succession Planning Performance

No succession planning elements are fully practiced by VHA

● Element fully practiced

○ Element not practiced

Succession planning element	Degree to which elements are practiced by VHA	Description
Proactively identifying succession needs		<ul style="list-style-type: none"> VHA workforce planning exercise creates national priority recruitment occupations each year Executive leadership not included among priorities Pipeline not regularly reviewed by VHA leadership
Identifying individual leaders		<ul style="list-style-type: none"> No formal identification of high potential leaders Some informal mentoring and referrals for leadership development programs
Developing leaders		<ul style="list-style-type: none"> Variety of programs available across federal government, although investment is decreasing Limited connection between leadership programs and succession needs Program navigation is left to employees
Connecting leaders to opportunities		<ul style="list-style-type: none"> Extended hiring process and lack of timely communication about status Significant number of vacancies at all leadership levels

SOURCE: Society for Human Resource Management; VHA interviews, 2015

These elements work together in many private sector settings to create a robust leadership pipeline. In interviews, multiple VHA employees, particularly HR administrators, expressed discomfort with applying these succession planning elements in the public sector due to possible conflict with Merit System Principles (5 USC, Section 2301) and pre-selection prohibitions, the threat of increased Equal Employment Opportunity (EEO) or Merit System Principle Board (MSPB) complaints, and bargaining restrictions. Therefore, HR administrators requested greater guidance from VHA before accepting that this approach would be possible.

Conversations with VHA leaders at VAMCs, VISNs, and VHACO revealed the impact of the lack of effective succession planning. Leaders expressed widespread concern over the lack of a systematic “enterprise” approach to succession planning, and “day-to-day” focus obscuring long-term thinking. More than half of the leaders interviewed shared this concern. Typical sentiments heard were:

- “Every time we turn around we have vacancies and no one to fill them. We are very thin.”
- “[When we talk about] Workforce Succession Planning, we really just give lip service to succession planning. We really do just truly workforce planning.”
- “We’ve not had an enterprise view [to succession planning]. I don’t have anyone or any system who can tell me where the opportunities are. I have an amazing obstetrician

The views, opinions, and/or findings contained in this report are those of the assessment team and should not be construed as an official government position, policy, or decision.

telling me she wants to join VA, and she's willing to move, and I don't know what to tell her."

- "I am retiring next month and there is no replacement for me – the top three leadership positions are vacant with no plan."
- "Succession planning? It doesn't happen here."

The evidence above indicates that VHA's current succession planning approach does not meet the needs of VHA. Instead, it results in a workforce planning exercise that only helps define priority occupations that will require hiring today and in the future. In interviews, the annual workforce planning process received mixed reactions, with a high level of awareness of the exercise but also a high level of skepticism that the workforce planning exercise has real influence on the ground. Further, the current process does not specifically address Quadrad-level leadership workforce planning issues, which VA has organized centrally in the Corporate Senior Executive Management Office (CSEMO).

With focused policies and improved communication to employees, succession planning is possible while complying with federal statutes. Within the Merit System Principles of fair and open competition, fair and equitable treatment, and protection against personal favoritism, there are opportunities to plan for merit-based leadership succession (5 USC, Section 2301). Leaders should encourage all qualified employees to apply for the formal leadership development programs to prepare them for positions and ensure eligibility. Candid and constructive feedback provided to those not selected for these programs will improve their preparation and application to such programs in the future. In addition, risk assessments conducted for critical leadership positions will identify near-term vacancies (for example, next six to nine months). In some cases, there could be opportunities to prepare vulnerable positions for these anticipated vacancies through double-encumbering key leadership positions. The interviews elicited a variety of these tactics, but there is no consistency or standardization across VHA leadership, and there is significant opportunity to develop a systematic approach to individual succession management, in the service of developing and deploying the next generation of VHA leaders.

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6 Leadership Development

6.1 Summary

In this report, leadership development is defined as “formal and informal training and professional programs designed for all management and executive-level employees to assist them in developing the leadership skills and styles required to deal with a variety of situations” (Society for Human Resource Management).

Leadership development extends beyond formal programs to also include mentoring, apprenticeship, and career experience. This is the lens through which we approached leadership development at VHA.

In determining how well VHA is developing the capabilities of current and future leaders through leadership development activities, we found:

- VHA’s lack of a comprehensive approach to leadership development has resulted in leaders unable to fully prepare for future roles.
- VHA’s formal programs are not linked to career paths, not well-coordinated, and thus do not result in a robust leadership pipeline.
- Multiple competency models in use at VHA result in inconsistent and incomplete leadership development programs.

As of early 2015, renewed efforts are underway, led by VHA’s Office of Workforce Services, to centrally address many of the topics described below.

Throughout this section, we draw on insights shared during interviews with VHA leaders as well as data from the OHI survey (VHA interviews, 2015; VHA OHI Survey, 2015). Unless otherwise cited, direct quotations are from VHA interviews and survey data are from the OHI survey. We also draw on various other primary source data and cite them as appropriate throughout the section.

6.2 Findings

6.2.1 VHA’s Lack of a Comprehensive Approach to Leadership Development Has Resulted in Leaders Unable to Fully Prepare for Future Roles

A comprehensive approach to leadership development is a combination of four activities:

- **Formal programs.** Structured opportunities for networking, reflection, goal-setting, and learning
- **Mentoring.** Access to role models who help define career paths and troubleshoot difficulties
- **Apprenticeship.** Opportunities to gain on-the-job experience for the next step in a career progression

- **Career experience.** Combined understanding of functions and expertise gained by climbing a career ladder over time.

VHA provides each of these activities, but focuses overwhelmingly on a system of formal programs that has, as one leader said, “faded away over the past few years” due to travel restrictions and reductions in training budgets. However, there is evidence of a recent renewed commitment to leadership development and reintroducing national training and mentoring programs (e.g. NExT and HCLDP; coach matching program). Aside from these formal leadership development programs, over 6,000 certified mentors are available for employees. Details and short-term assignments are sometimes available (in some cases a byproduct of high leadership vacancy rates) to build experience for potential positions. (VHA Office of Workforce Services, 2015). Even so, these programs and similar efforts are insufficient to address the current leadership gaps and needs.

With declining formal programs and no unified approach to tie together the other elements of leadership development, employees are left to piece together these activities on their own. This has led to concerns expressed in interviews that “we are setting up some of our leaders to fail.” More than 40 percent of Pentad leaders and 30 percent of non-Pentad leaders interviewed echoed the sentiment that VA’s investment in leadership development has been insufficient in recent years. The result is leaders who are not able to bring the full capability and resources of VHA to bear on the needs of the Veteran.

6.2.2 VHA’s Formal Programs Are Not Linked to Career Paths, Not Well-Coordinated, and Thus Do Not Result in a Robust Leadership Pipeline

In its 2014 Interim Workforce and Succession Strategic Plan, VHA candidly describes the state of its leadership development approach and acknowledges three current challenges, all of which have been observed throughout this assessment:

Career. “The lack of clear career ladders or logical paths of progression from entry through upper levels of leadership makes the system confusing to navigate and negotiate.”

Program coordination. “Because the overall system of leadership development is not synchronized or aligned, there are overlaps and gaps between the programs.”

Investment decisions. “Student capacity is driven by budgetary and other constraints, not by actual need for graduates” (2014 VHA Interim Workforce and Succession Strategic Plan, 2014).

Interviews and analyses from this assessment support the previous findings noted above. Regarding career paths, interviews reveal that leadership progression at VHA is predominantly self-directed, with motivated employees applying for programs and responsible for piecing together a career path through these programs. Planning support is not offered in many VAMCs, which can lead to missed opportunities or enrollment in trainings that are not the best fit for an employee’s career path and potential. In addition, the timing is such that many leadership programs are for individuals already occupying positions for which training is being provided. As one interviewee told us, “I wish I had this before I started the job – that’s when I could have used it the most.”

Regarding program coordination, no single entity coordinates leadership development in VHA – there are at least 19 entities within VHA, VA, and the federal government that offer at least 30 leadership development programs in aggregate (VHA Office of Workforce Services, 2015). The mentality as described by a VHA leadership development leader is that “everyone wants to hang on to their own piece,” which has led to “no consistent ownership and a lack of coordination.”

Regarding investment decisions, investment and enrollment in leadership development programs have decreased in recent years, resulting in limited access for leaders in need of these programs. In data provided by VHA, the number of graduates across seven key programs decreased 24 percent between 2011 and 2014 to 1,800 graduates across all levels of VHA, while overall investment decreased 14 percent between 2013 and 2014 (VHA Healthcare Talent Management Office, 2015). Interviewees report that access to programs has been limited because of travel restrictions and VHACO approval delays. In addition, interviews with federal officials involved with Senior Executive Service (SES) programs revealed that VHA has not offered a Career Development Program for senior positions in recent years, a program that is a standard across federal agencies. Efforts to restart this program are underway (Office of Personnel Management, 2015).

In an environment with decreasing resources, VHA has limited insight into which programs are the best use of limited funds. VHA officials involved with leadership development programs told us, “We don’t have good measurement of our programs.” Outside of satisfaction surveys, interviews did not reveal any evaluation of leadership development programs (such as whether trainees were connected to the jobs for which they were trained) or of employee performance in new roles after completion of training or coaching programs.

6.2.3 Multiple Competency Models and Frameworks in Use at VHA Result in Inconsistent and Incomplete Leadership Development Programs

One education expert at VHA told us, “We don’t have a consistent competency model that has been blessed and sent to the field.” At least four models or frameworks exist currently. The VHA High Performance Development Model is a health care-centered competency model favored within VHA and used to inform some trainings, but it is distinct from VA competencies endorsed by the VA Learning University (VALU) that are predominantly used in performance management settings. These are both separate from qualifications required by OPM for senior executives. All are detailed in **Figure 6-1**.

Figure 6-1. Competency Models in Use

Four competency models and frameworks compete to prepare and evaluate VHA leaders

VHA High Performance Development Model	VA Leadership Competencies	VA All Employee Competencies	OPM ECQs (Executive Core Qualifications)
<ul style="list-style-type: none"> ▪ Personal mastery ▪ Technical skills ▪ Interpersonal effectiveness ▪ Customer service ▪ Flexibility/adaptability ▪ Creative thinking ▪ Systems thinking ▪ Organizational stewardship 	<ul style="list-style-type: none"> ▪ Leading people ▪ Partnering (building coalitions) ▪ Leading change ▪ Results driven ▪ Global perspective ▪ Business acumen 	<ul style="list-style-type: none"> ▪ Communication ▪ Interpersonal effectiveness ▪ Critical thinking ▪ Organizational stewardship ▪ Veteran and customer focus ▪ Personal mastery 	<ul style="list-style-type: none"> ▪ Leading change ▪ Leading people ▪ Results driven ▪ Business acumen ▪ Building coalition

SOURCE: VHA Office of Workforce Services, 2015

While there is no competency consensus at VHA, a review of private sector health care leadership standards reveals six capabilities that are commonly expected of high-performing leaders. These include:

- **Stakeholder management**, including external affairs and bureaucracy navigation
- **Financial acumen**, including resource management and fiscal stewardship
- **Operational excellence focus**, including relentless attention to clinical outcomes and a continuous improvement orientation
- **Strategic thinking**, including establishing mission and direction and leading change
- **People leader**, including coaching, developing, and influencing others
- **Technical mastery**, including high competence in native discipline and continuing contribution to that discipline (Interviews with leading systems).

As **Figure 6-2** shows, each of these is found, at least in part, in VHA's existing models and frameworks, but they are neither found in every model, nor for every type of leader (VHA Healthcare Talent Management Office, 2015). For example, leaders who attend trainings based in VHA's High Performance Development Model may not specifically receive in-depth business or financial skills unless they also attend a training that is influenced by the VA Leadership

competencies, the latter of which more consistently addresses these skills. A standardized, comprehensive view would guard against both inconsistent preparation and expectations across VHA and also possible gaps in competencies.

Figure 6-2. Leadership Capabilities

Capabilities required of health care leaders are not universally found in existing VHA competency models and frameworks

Benchmark capability	VHA High Performance Development Model	VA Leadership Competencies	VA All Employee Competencies	OPM ECQ
Stakeholder management		✓		✓
Financial acumen		✓		✓
Operational excellence focus		✓		✓
Strategic thinking	✓	✓	✓	✓
People leadership	✓	✓		✓
Technical mastery	✓		✓	✓

SOURCE: VHA Workforce Management and Consulting, 2015

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7 Culture

7.1 Summary

This report defines the culture of an organization as the “collection of overt and covert rules, values, and principles that are enduring and guide organizational behavior” (Burke and Litwin, 1992) or more simply “the way things are done around here” (*McKinsey Quarterly*, 2003). Other common definitions often talk about the mindsets and behaviors of an organization. Despite these relatively simple definitions, the culture of any organization is a complex and interconnected construct.

To understand and evaluate the culture at VHA, this report used in-depth analyses of data obtained from surveys including the Organizational Health Index (OHI), the Federal Employee Viewpoint Survey (FEVS), the VA All Employee Survey (AES), and interviews.

Examination of the culture found in VHA reveals a few practices that are powerful enablers of the mission and several cultural practices that are making the mission much more difficult to achieve. Study findings are as follows:

- Throughout all levels of the organization, employees and leaders share in their dedication to the mission of caring for Veterans.
- VHA employees want to move from a bureaucratic, political, and siloed organization to one defined by accountability, trust, and efficiency.
- Risk-aversion permeates all levels of VHA.
- There exists a pervasive lack of trust throughout VHA.
- The OHI Survey reflects poor organizational health across all nine outcomes.
- VHA does not currently align with any of the OHI archetypes for high-performing organizations.

In addition, while out of scope of this report, it also became clear throughout interviews that the broader VA culture has an impact on VHA culture.

Throughout this section, we draw on insights gathered during interviews with VHA leaders as well as data from the OHI survey (VHA interviews, 2015; VHA OHI Survey, 2015). Unless otherwise cited, direct quotations are from VHA interviews and survey data are from the OHI survey. We also draw on various other primary source data and cite them as appropriate throughout the section.

7.2 Findings

7.2.1 Throughout All Levels of the Organization, Employees and Leaders Share in Their Dedication to the Mission of Caring for Veterans

Within all ranks of VHA, there is an almost universal embrace of the mission of caring for Veterans. In interviews with employees ranging from front-line nurses to leadership, this mission is frequently cited as the most important reason why people come to work. At every

VAMC where we conducted site visits, at least one leader interviewed at each facility endorsed the value that the workforce placed on “commitment to the mission” (VHA interviews, 2015). Roughly half of the interviewees mentioned commitment to the Veteran. Representative quotes include:

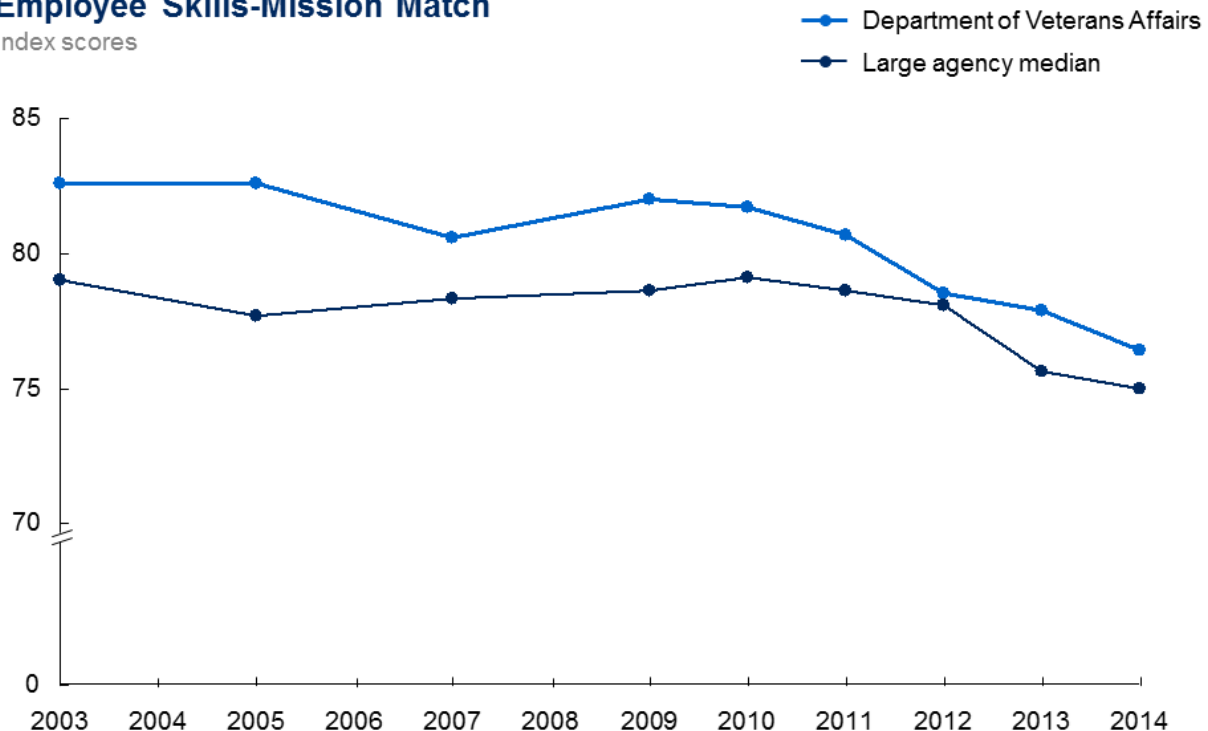
- “Our mission is the glue. It binds people together to get the work done.”
- “Taking care of Veterans is not just a phrase, but it is an action.”
- “It’s an honor to serve Veterans.”
- “[Our] canteen sells out of VA Employee jackets. People are proud to wear them, proud of where they work.”
- “You won’t find a more dedicated staff who do whatever and however is necessary to work.”

This dedication to the mission of caring for Veterans is also reflected in the FEVS. One of the trends in it is Employee Skills-Mission Match, which “assesses the level to which employees get satisfaction from their work and understand how their jobs are relevant to the organizational mission” (Partnership for Public Service and Deloitte, *The Best Places to Work in the Federal Government*, 2014; FEVS, 2014). This is the only category in which VA consistently leads the Large Agency median **[Figure 7-1]**.

Figure 7-1. Employee Skills-Mission Match

Employee Skills-Mission Match

Index scores



Employee Skills-Mission Match is the only category that consistently exceeds the large agency median

SOURCE: Partnership for Public Service and Deloitte, The Best Places to Work in the Federal Government, 2014

7.2.2 VHA Employees Want to Move From a Bureaucratic, Political, and Siloed Organization to One Defined by Accountability, Trust, and Efficiency

One aspect of the OHI Survey addresses organizational values. This “value mapping section” gives respondents the opportunity to identify those values or characteristics that most represented the current state of VHA as well as those desired values or characteristics they would like to see VHA move toward in the future. Five values, including two of the ICARE values¹⁰, were identified as both current and desired: Veteran focus, being of service to others, caring, commitment, and advocacy [Figure 7-2].

However, among the values most commonly seen in the current state, employees also mentioned “bureaucracy,” “internal politics,” “hierarchical,” and “siloed.” The other three ICARE values – “integrity,” “respect,” and “excellence,” were included in desired values but not current. In addition, VHA employees want to see the organization move from a siloed, slow-moving, and bureaucratic organization to a collaborative, efficient organization with a focus on excellence – and an organization focused on the Veteran and on the employee. The slow-

¹⁰ The ICARE values are VA’s core values and include integrity, commitment, advocacy, respect, and excellence.

moving, siloed bureaucracy acts as a significant barrier to helping provide each Veteran the unique care he or she needs.

Figure 7-2. Current and Desired Values

Difference between current and desired values

Top 15 current and desired values

CURRENT VALUES Where we are today ...	CURRENT & DESIRED VALUES What we'd like to continue ...	DESIRED VALUES Where we'd like to be ...
Bureaucracy	Veteran focus	Accountability
Internal politics	Being of service to others	Continuous improvement
Having a noble purpose	Caring	Being Collaborative
Slow-moving	Commitment ¹	Excellence ¹
Hierarchical	Advocacy ¹	Efficiency
Inconsistent		Integrity ¹
Silos		Well organized
Making a difference		Respect ¹
Contributing to the greater good		Employee focus
Conflict		Professional growth

¹ ICARE value

SOURCE: VHA OHI Survey 2015 (N=13,712)

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7.2.3 Risk-Aversion Permeates All Levels of VHA

Employees at VHA, ranging from front-line nursing staff up to VISN Directors, are notably risk-averse. The current culture found in VHA is one in which employees are “afraid to raise their hand to call something out.” Interviews throughout the organization support this finding. At almost every facility visited, at least one leader interviewed mentioned that risk-aversion and a reluctance to “speak up” were a significant issue. Three out of every four leaders interviewed at VISNs in which site visits were conducted echoed this concern. Additionally, VHA employees cited a lack of psychological safety as one of their main concerns (VHA interviews, 2015). One leader explained, “Risk-aversion permeates the VHA.” The effect on the Veteran is a staff conditioned towards compliance with rules versus focused on effective delivery of care.

The OHI provides additional evidence [Figure 7-3]. Specifically, the OHI looks at the following management practices when considering risk-aversion: “Consequence management,” “risk management,” “open and trusting,” and “supportive leadership.” When compared against the public sector and health care benchmarks, VHA scores demonstrably lower on each practice –

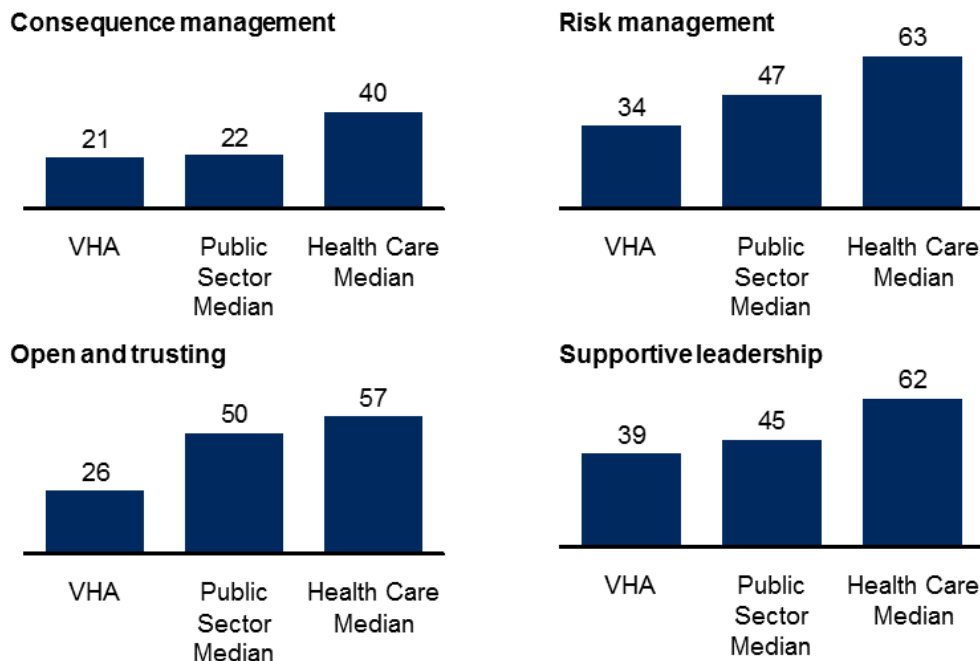
and even public and healthcare sector benchmarks, it should be noted, are in the bottom quartile of all respondents.

Figure 7-3. Risk-Aversion

Risk aversion permeates the organization

OHI VHA vs. benchmark

Percent of respondents who frequently observe behaviors related to each of the practices below



SOURCE: VHA OHI Survey 2015 (N=13,712); Global Benchmark (N=1,259,322, no. surveys=737); Public Sector Benchmark (N=47,159, no. surveys=27); Health Care Systems and Services Benchmark (N=40,437, no. surveys=33)

7.2.4 There Exists a Pervasive Lack of Trust Throughout VHA

Within VHA, there appears to be a significant lack of trust among employees across levels. Some Medical Center Directors spoke of not trusting VHACO, and some VHACO officials spoke similarly of Medical Center leaders. Front-line supervisors stated they did not trust the leadership within the facility. Representative quotations from interviews include:

- “There is an opportunity for improvement, an opportunity for trust.”
- “Trust? Not a lot. People do trust the Director, but have mixed trust of the Quad, and less trust in lower leadership.”
- “Lack of trust leads to micromanagement.”
- “Everyone is so worried about getting into trouble or losing their job. Trust is lacking through the organization.”
- “We need to encourage innovation and empower front-line to make decisions. This may be a trust issue. I’m seeing hesitation because they don’t want to do something wrong.”

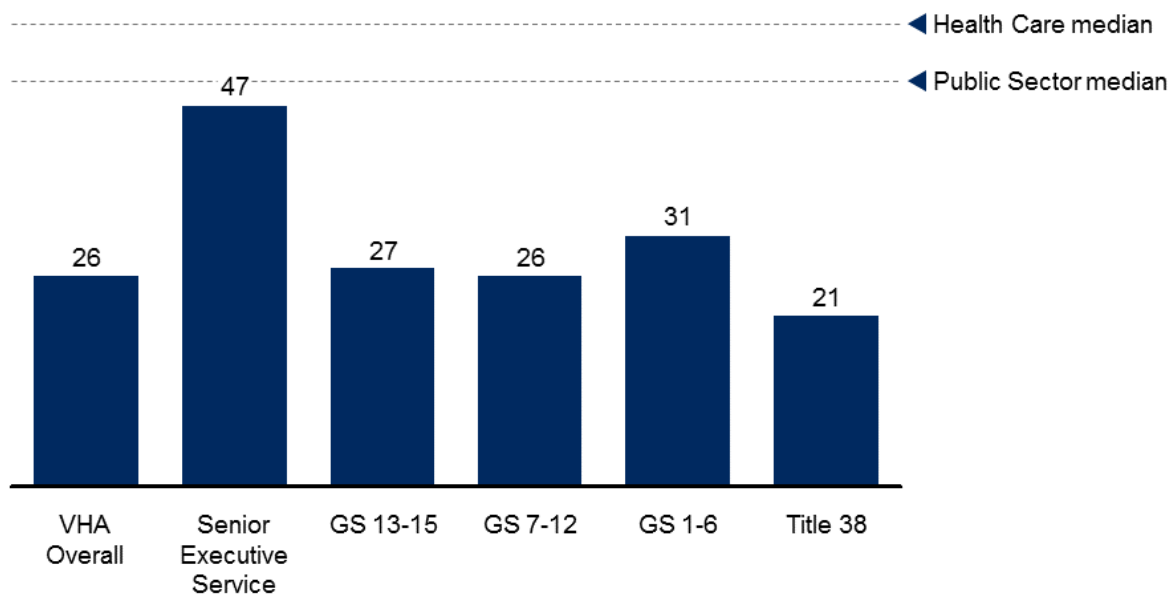
- “We’ve developed hopelessness and helplessness: helpless to fix things, and hopeless that anyone else would help.”

Analyses of the OHI data centered around the open and trusting nature of the work environment corroborate this **[Figure 7-4]**. Across levels of employment, this practice is in the lowest quartile. SES rank the practice significantly higher than other segments, 47 compared to 21 to 31. This may be due to senior leaders having greater visibility into the full set of reasons for VHA’s major actions, increasing their level of trust in the organization.

Figure 7-4. Open and Trusting

VHA employees’ view of trust vs. benchmarks

Percent of respondents who frequently observe the following behaviors:
 “Managers consult with employees on issues that affect them” and
 “Managers encourage honesty, transparency, and candid, open dialogue”



SOURCE: VHA OHI Survey 2015 (N=13,712); Global Benchmark (N=1,259,322, no. surveys=737); Public Sector Benchmark (N=47,159, no. surveys=27); Health Care Systems and Services Benchmark (N=40,437, no. surveys=33)

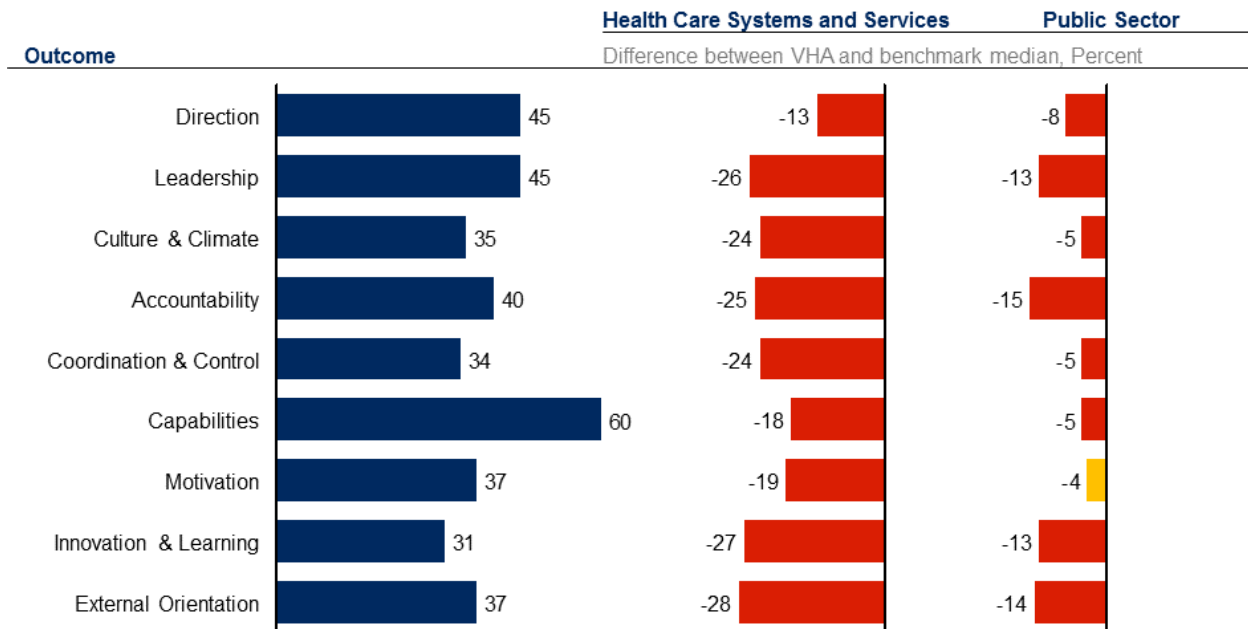
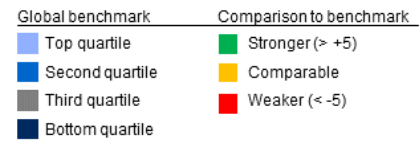
7.2.5 The OHI Survey Reflects Poor Organizational Health Across All Nine Outcomes

The OHI survey affords the opportunity to benchmark VHA’s organizational health against other similar organizations. When compared to peers, VHA lags in every outcome (the current state of an organization), and each organizational health outcome lies in the bottom quartile of all survey respondents **[Figure 7-5]**.

Figure 7-5. VHA Outcomes Compared to Benchmarks

When compared to peers and the global benchmark, VHA lags in every outcome

Percentage agreement on outcome effectiveness



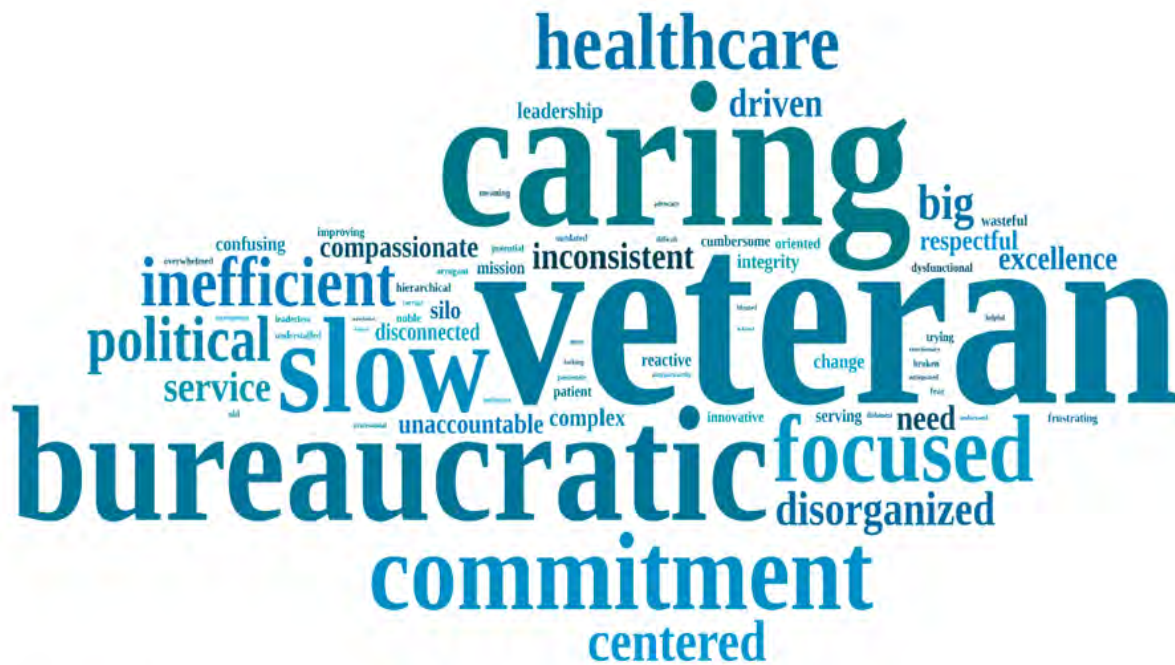
SOURCE: VHA OHI Survey 2015 (N=13,712); Health Care Systems and Services (N=40,437, no. surveys=33), Public Sector (N=47,159, no. surveys=27)

This performance is also reflected in the practices (the actions an organization takes to achieve results). Examining the 37 management practices, VHA scores in the bottom quartile of 35 of 37 of them. Only two practices, shared vision and Veteran focus, scored in the third quartile, reflecting a strong commitment to the purpose of caring for Veterans, a sentiment echoed resoundingly in interviews as well.

The OHI also included several open text questions. An assessment of open text responses requesting three words that describe VHA reveals a number of recurring themes. Language around Veterans, care, and bureaucracy was most common. **Figure 7-6** shows a visual analysis of the frequency of words, with the size of the word reflective of the relative frequency with which the word showed up in the open text responses. This is consistent with the themes we heard in our interviews.

Figure 7-6. Three Words Describing VHA

A visual analysis of open text responses reveals a number of themes, including bureaucracy and Veteran-centered care



NOTE: Size of word reflects frequency of response when asked for 3 words that define VHA

SOURCE: VHA OHI Survey 2015 (N=13,712); analysis of open text responses

7.2.6 VHA Does Not Currently Align With Any of the OHI Archetypes for High-Performing Organizations

Within high-performing organizations, McKinsey has identified four distinct archetypes of healthy organizations, based on the signature mixes of practices that organizations deploy to create a coherent and effective management system.

The first, “leadership-driven,” is manifested by inspirational leaders who are the performance catalyst, setting high expectations and helping the organization achieve those expectations. The second, “market-focused,” is characterized by an organization with strong customer focus, competitive insights, and valuable business partners. The third archetype, “execution edge,” is represented by organizations that leverage the knowledge of employees at all levels and outperform the competition through superior execution, and continuous improvement. The final archetype is characterized by the “collective talent and knowledge” of the organization and success depends on developing it effectively.

There is not a one-size-fits-all, or single “best practice” way to achieve sustainable performance and health – all four of these archetypes are different proven paths to success. Moreover, no organization can manage all 37 organizational health practices equally – focusing on the

winning recipes of select practices with known synergies is likely to be most successful in the long run. These archetypes can provide areas of focus.

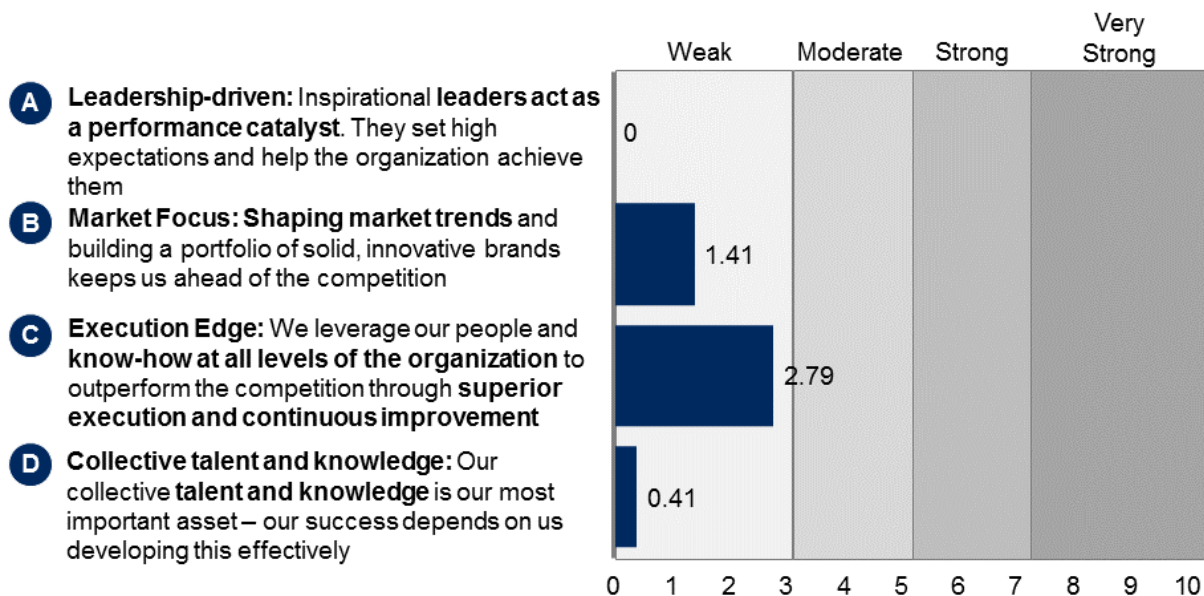
Importantly, organizations that align very strongly to any of the four archetypes have a five times greater chance of being healthy than peers with weak alignment. Organizations that align very strongly to an archetype tend to have top quartile OHI scores, while those with no alignment have bottom quartile OHI scores.

Today, VHA does not align strongly with any of these specific archetypes, but aligns weakly with the “execution edge” and “market focus” archetypes [Figure 7-7]. Most high performing public sector organizations align with the “execution edge” archetype – and most high-performing health care organizations align with either the “market focus” or “execution edge” archetypes: 50 percent of top quartile provider organizations align to “market focus,” and 33 percent align to “execution edge.” VHA should make a deliberate push to more strongly align with a chosen archetype.

Figure 7-7. Archetypes

VHA aligns weakly with Market Focus and Execution Edge

Archetype similarity based on current relative practice ranking



The 4 archetypes reflect different core beliefs on value creation and success. Organizations with Very Strong alignment to one of the 4 proven archetypes have a 5 times greater chance of organizational health than those with Weak alignment

SOURCE: VHA OHI Survey 2015 (N=13,712)

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8 Employee Engagement

8.1 Summary

For this assessment, employee engagement is defined as “the employee’s sense of purpose that is evident in their display of dedication, persistence, and effort in their work and overall attachment to their organization and its mission” (Executive Office of the President and OPM, 2014). We focused on the current state of employee engagement, as well as the extent to which leaders influence employee engagement through role modeling, fostering understanding and conviction, and rewards and recognition.

Findings include:

- At VHA, in general, employees feel a strong sense of commitment to caring for Veterans, but they do not feel as much commitment from the organization.
- Employees experience a challenging work environment and “burnout.”
- Many VHA employees do not feel well informed or listened to by leadership.
- Reinforcing engagement and behavior with formal mechanisms happens in limited pockets, but faces several constraints, including limited access to positive reinforcement mechanisms, a weak culture of appreciation, and heavily burdensome processes for progressive discipline.

Throughout this section, we draw on insights shared during interviews with VHA leaders as well as data from the OHI survey (VHA interviews, 2015; VHA OHI Survey, 2015). Unless otherwise cited, direct quotations are from VHA interviews and survey data are from the OHI survey. We also draw on various other primary source data and cite them as appropriate throughout the section.

8.2 Findings

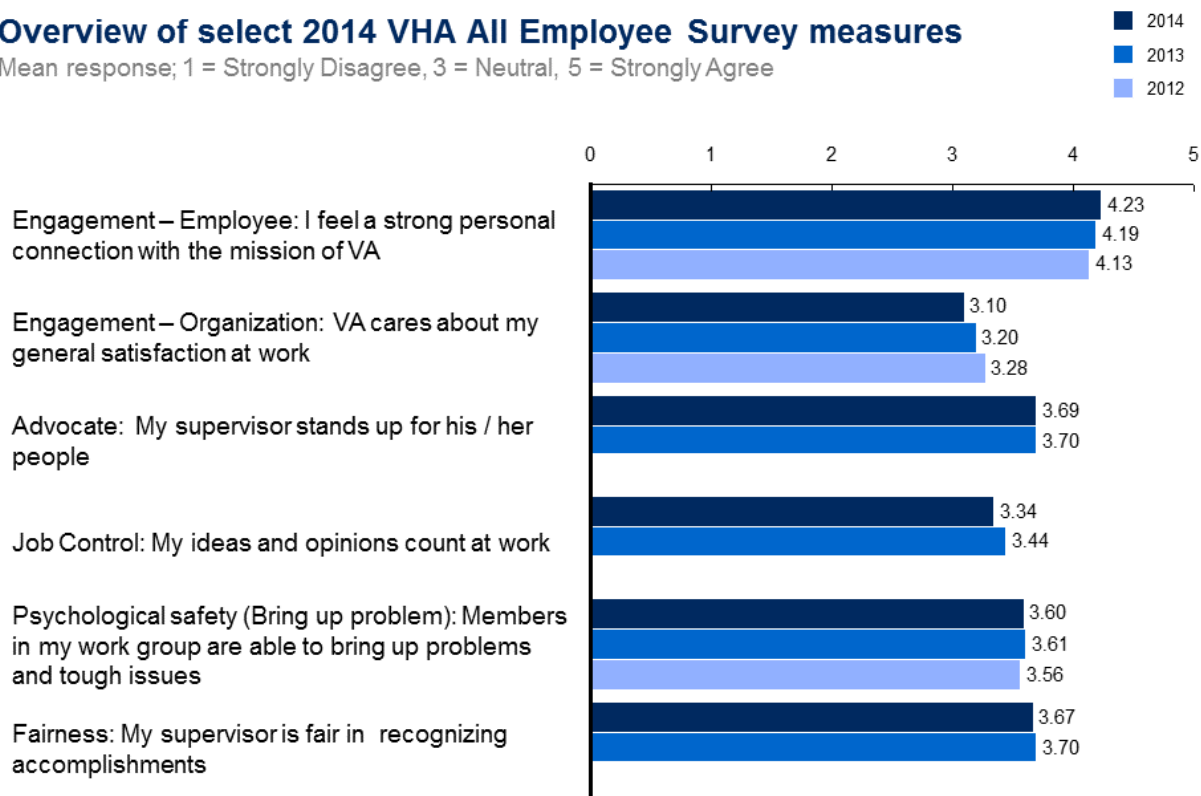
8.2.1 At VHA, in General, Employees Feel a Strong Sense of Commitment to Caring for Veterans, but They Do Not Feel as Much Commitment From the Organization

The annual AES shows a current measure of employee satisfaction across VA. While many of the questions touch elements of employee engagement, two are most salient as a starting point for this discussion of employee engagement. “Engagement – Employee” is the highest of all 2014 AES measures (4.23, the only measure above 4 on the 5-point scale), and reflects the personal connection employees feel to the mission of VA. Meanwhile, “Engagement – Organization” is one of the weakest scores in 2014 (3.10), and reflects the general sentiment that employees do not perceive VA to care about their general satisfaction at work (VA, All Employee Survey, 2014) [Figure 8-1].

Figure 8-1. Select Measures from AES

Overview of select 2014 VHA All Employee Survey measures

Mean response; 1 = Strongly Disagree, 3 = Neutral, 5 = Strongly Agree



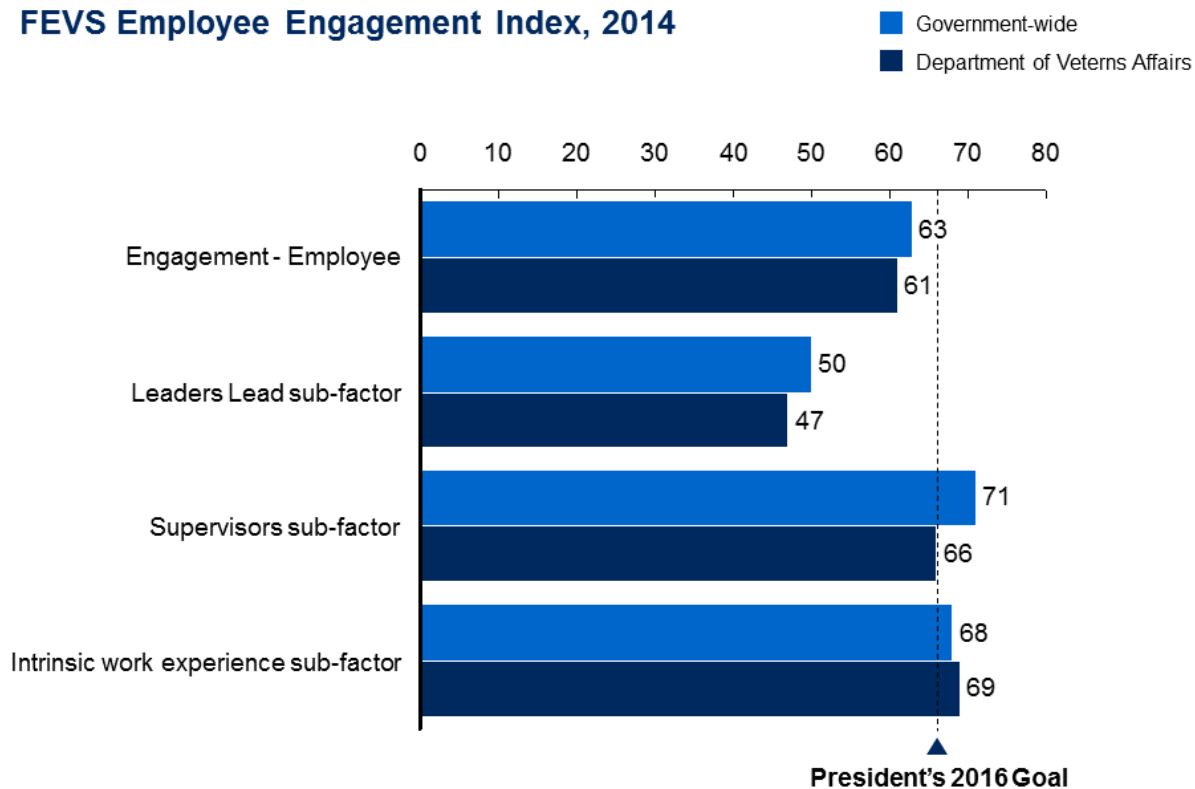
SOURCE: VA, All Employee Survey, 2014

Furthermore, the Employee Engagement Index in the Federal Employee Viewpoint Survey (FEVS) is a measure of the engagement potential of an agency's work environment (i.e., the conditions that lead to engagement). In support of the President's Management Agenda Cross-Agency Priority (PMA CAP) goal on people and culture, the Obama administration set a goal to raise this government-wide engagement score to 67 percent by the 2016 FEVS. However, VA followed the government-wide trend with the index of both groups decreasing in 2014 (61 percent and 64 percent, respectively) (Partnership for Public Service and Deloitte, *The Best Places to Work in the Federal Government*, 2014; FEVS, 2014).

VA ranks in the bottom quartile of the category Large Agencies for the total index, as well as the Leaders Lead and Supervisors sub-factors. Conversely, VA is higher than the government-wide average for the Intrinsic Work Experience sub-factor and ranks in the third quartile for Large Agencies. This is consistent with the overall finding of the employees' commitment to the mission of caring for Veterans [Figure 8-2].

Figure 8-2. FEVS Employee Engagement Index

FEVS Employee Engagement Index, 2014



SOURCE: OPM, Federal Employee Viewpoint Survey 2014

However, efforts are underway to improve employee engagement. The Office of Management and Budget (OMB), OPM, and the Presidential Personnel Office sent a memo to agency leaders in November 2014 with suggested strategies to raise this Employee Engagement Index score. The memo recommends identifying appropriate FEVS metrics to incorporate into SES and manager performance plans, cascading through to supervisors (Executive Office of the President and OPM, “Strengthening Employee Engagement and Organizational Performance, 2014). Guidance was sent from Secretary McDonald to include a “measurable component related to action planning and/or results to improve employee engagement or based on employee feedback” (VA, Senior Executive Performance for Fiscal Years [FY] 2014 and 2015, 2015).

Our interviews echo these themes. Recurring themes around commitment to the Veteran were:

- “I’m from a family of Veterans – this mission is personal to me.”
- “We are committed to the Veterans, but we also have a great lifestyle.”
- “I’m here for our Veterans.”
- “People are committed and have a strong sense of the mission.”

- “Clinicians are dedicated to patients, and there is a special meaning that these people serve our country.”

Themes around lack of organizational support from leadership include:

- “It needs to be a two-way street. They [leaders] need to seek to understand not just speak.”
- “Our staff’s morale is impacted negatively by the fact that they’re always asked to do more with no additional resources – nothing is ever taken off the to-do list.”
- “Burnout is real.”
- “We need to make employees feel like what they think matters. Huddleboards have been really good for this.”

This is also reflected in the OHI data, which, as shown previously in **Figure 7-2**, demonstrate that while Veteran focus is highlighted as both a current and desired value, both employee focus and professional growth were identified as desired values but not as current (see Section 7).

8.2.2 Employees Experience a Challenging Work Environment and “Burnout”

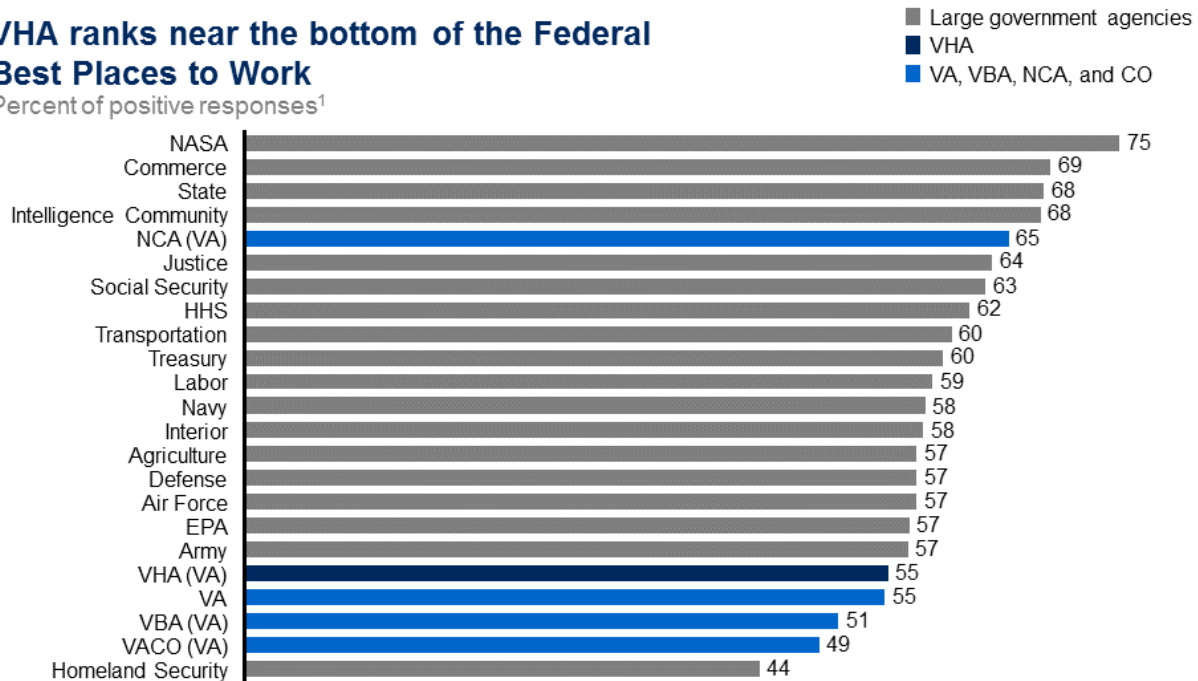
Interviewees have shared that employees experience a complex operating environment, including silos, inadequate and often one-way communications, limited access to resources, Congressional inquiries, and ongoing “thrashings” from the press. Many employees feel a lack of empowerment in resolving issues.

VHA ranks near the bottom in the federal government’s “Best Places to Work Survey,” where VA finished above only the Department of Homeland Security in rank among large federal agencies (Partnership for Public Service and Deloitte, *The Best Places to Work in the Federal Government*, 2014) [**Figure 8-3**].

Figure 8-3. Federal Best Places to Work

VHA ranks near the bottom of the Federal Best Places to Work

Percent of positive responses¹



¹ The Best Places to Work index score is calculated based on 3 different questions in the Office of Personnel Management's Federal Employee Viewpoint Survey (FEVS)

1. I recommend my organization as a good place to work (Q. 40)
2. Considering everything, how satisfied are you with your job? (Q. 69)
3. Considering everything, how satisfied are you with your organization? (Q. 71)

The overall index score measures the performance of agencies and agency subcomponents related to employee satisfaction and commitment. The index is weighted according to the extent to which each question predicts "intent to remain"

SOURCE: Partnership for Public Service and Deloitte, *The Best Places to Work in the Federal Government*, 2014

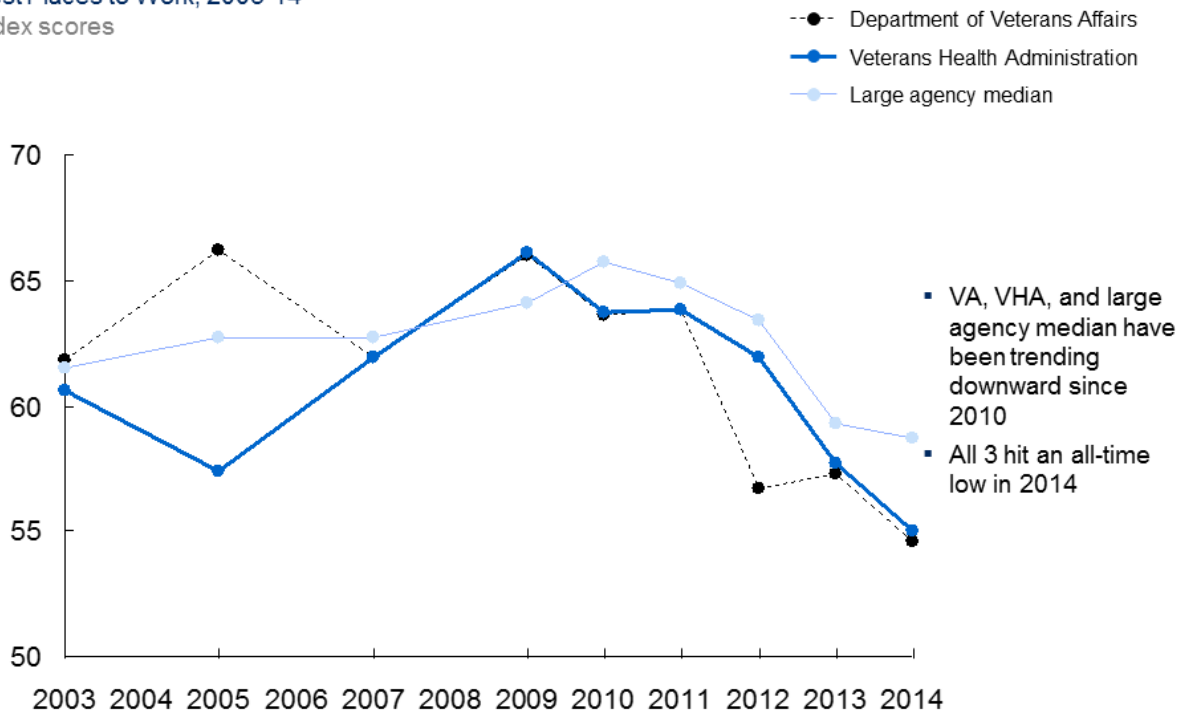
Looking at VA's and VHA's trends over time, they have generally mirrored the large agency median since 2010, as all three have gone downward. All hit an all-time low in 2014 (Partnership for Public Service and Deloitte, *The Best Places to Work in the Federal Government*, 2014) [Figure 8-4]. It should also be noted that the window of responses was between May 6 – June 13, 2014, at the height of the scheduling crisis, which is a likely driver of VA's and VHA's low scores in 2014.

Figure 8-4. FEVS: VA and VHA Compared to Large Agency Median

VA and VHA have been lower than the large agency median since 2010

Best Places to Work, 2003-14

Index scores



SOURCE: Partnership for Public Service and Deloitte, The Best Places to Work in the Federal Government, 2014

Burnout is also a concern. The 2014 AES evaluated the level of burnout experienced by employees within VHA as somewhat higher than in 2013 (2.17 compared to 2.05, with lower numbers being more favorable). The specific burnout measures evaluated by the AES asked employees to share how often they “feel burned out from work,” “worry that this job is hardening” them, and whether or not they feel they have “accomplished many worthwhile things in this job.” While the AES does not compare its survey against external benchmarks for these measures, the answers indicate that burnout is a major concern for VHA employees. Employees “feel burned out from work” a few times a month. They “worry the job is hardening” them and feel they “have accomplished many worthwhile things in this job” once a month or less (VA, All Employee Survey, 2014).

This can have negative effects on the Veteran as he or she moves through the system. Burnout, as a measure of employee enthusiasm and excitement to come to work each day, is especially worrisome in a health care setting, where direct patient care is central to outcomes and the Veteran experience, and in a system where there is already strain on workforce planning and succession planning. Burnout may exacerbate the challenges of keeping VHA staffed to meet the needs of the patient population.

In recent years, RN “quits,” defined as voluntary departures, exclusive of retirements, terms, and reductions in force (RIFs), have grown four times as fast as the nursing population itself: between 2011-2014, nurse employment grew by an average of four percent per year, while nurse quits grew by an average of 17 percent per year (OPM, FedScope, accessed 2015). As the system works hard to keep its nurses and recruit new ones, keeping an engaged and committed employee base will be essential, and managing burnout will be part of that.¹¹

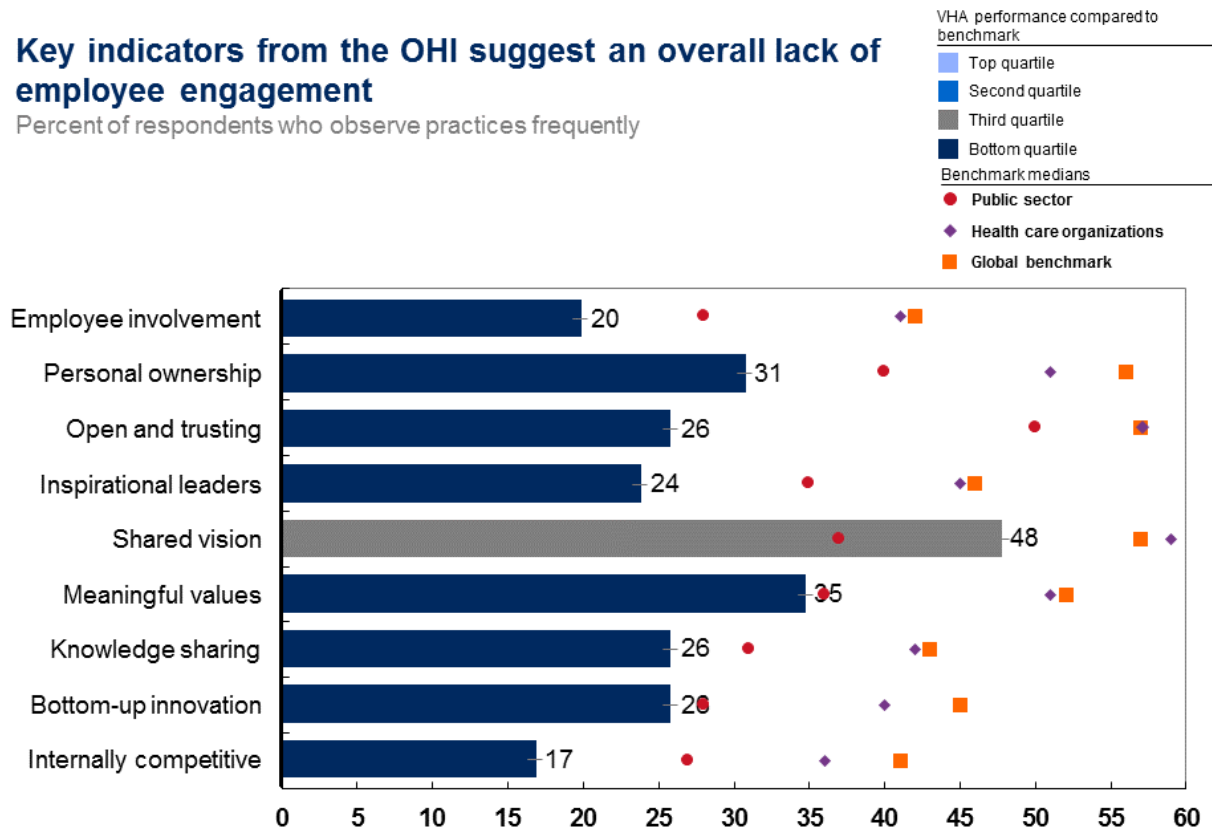
A low level of employee engagement across VHA is reflected in the OHI as well. Across nine management practices that drive employee engagement, ranging from “personal ownership,” to “inspirational leadership,” to “shared vision” and “meaningful values,” to “how ideas spread through the organization,” VHA is lagging far behind the public sector, health care, and global benchmark. “Shared vision” is in the third quartile; all others are in the bottom quartile [Figure 8-5].

¹¹ The team looked at RNs (OPM classification 0610) for two reasons. First, it is the largest population of VHA employees and second on the list of Mission Critical Occupations according to VHA’s 2014 Interim Workforce and Succession Strategic Plan. Second, this group was chosen because of its size and its relative similarity to the overall population with respect to burnout: in the most recent AES, 8.2 percent of RNs fit VA’s burnout profile, compared to 8.8 percent of the overall VA population.

Figure 8-5. Employee Engagement

Key indicators from the OHI suggest an overall lack of employee engagement

Percent of respondents who observe practices frequently



SOURCE: VHA OHI Survey 2015 (N=13,712); Global Benchmark (N=1,259,322, no. surveys=737); Public Sector Benchmark (N=47,159, no. surveys=27); Health Care Systems and Services Benchmark (N=40,437, no. surveys=33)

8.2.3 No Consensus Exists About VHA Employees Being Well Informed or Listened to by Leadership

Communication is a critical component of employee engagement and an integral way to foster understanding and commitment. The team observed wide variability in strength of communication across the facilities we visited. This was often highly dependent upon the strength of the Pentad leaders and employees' direct supervisors. On the whole, the AES indicates that many employees recognize their supervisors communicating information to them – VHA's average score for information-sharing was 3.65 in 2014 (VA, All Employee Survey, 2014). In spite of this relatively strong score, however, much of what we heard in interviews suggests that communication breakdowns can occur at every level in the organization, from Central Office to the front-line. Byproducts of this include some employees' perception that leadership does not care about them, limited clarity around performance expectations, and employee hesitation to speak up.

Representative quotes include:

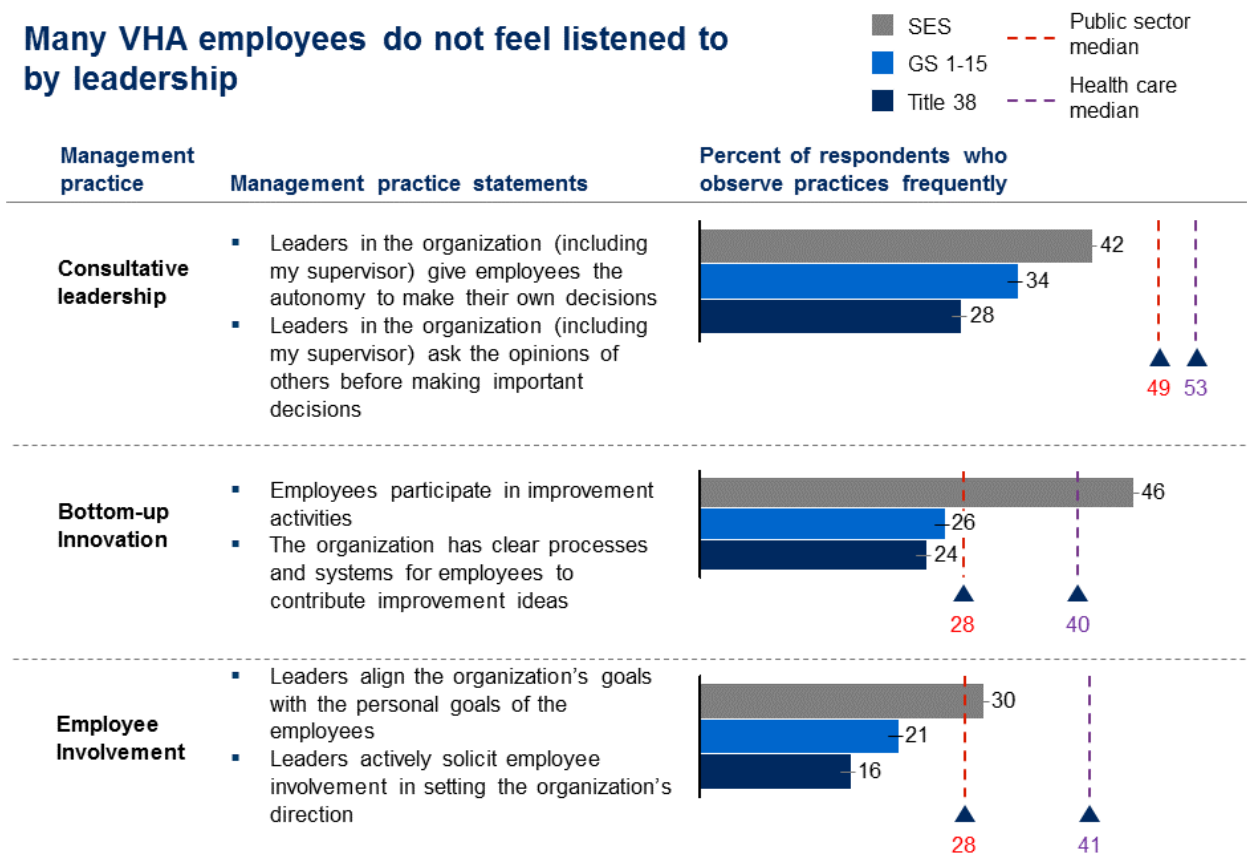
- "VA works in silos, which leads to communication gaps."

- “There are some supervisors who do not communicate well. When they don’t communicate it makes it harder on the employees and you see it in the morale.”
- “The biggest problem is that employees don’t always know or understand what needs to be done in order to get an Excellent or Outstanding on their review, because supervisors don’t communicate well.”
- “Open communication and awareness remains a challenge across all levels.”
- “We see a lot of ‘I’m gonna do what my supervisor tells me and keep my opinions to myself.’”

The OHI shows a gap between SES and other groups on consultative leadership, bottom-up innovation, and employee involvement, three practices that reflect both how much leaders consult with their employees, and the extent to which new ideas and innovations stem from front-line employees [Figure 8-6]. This suggests a disconnect between what senior leaders are trying to communicate about encouraging innovation, and what employees are hearing.

Figure 8-6. Listening

Many VHA employees do not feel listened to by leadership



SOURCE: : VHA OHI Survey 2015; SES (N=62); GS 1-15 (N=9,425); Title 38 (N=2,900); Public Sector Benchmark (N=47,159, no. surveys=27); Health Care Systems and Services Benchmark (N=40,437, no. surveys=33)

There are some bright spots around communication that should be noted, including several facilities where employees speak of an “open door culture” (e.g., Durham, NC and Pittsburgh,

PA). Meanwhile, the leadership at the St. Louis, MO, VAMC offer a “10-M” program, where employees can sign up to speak with the Director for 10 minutes about anything on their mind.

8.2.4 Reinforcing Engagement and Behavior With Formal Mechanisms Happens in Limited Pockets, But Faces Several Constraints, Including Limited Access to Positive Reinforcement Mechanisms, a Weak Culture of Appreciation, and Heavily Burdensome Processes for Progressive Discipline

Reinforcing employee engagement and behavior with formal reward and recognition mechanisms happens in a limited way but faces several constraints. There is some use of reward and recognition – including facilities that use an array of recognitions, such as, Employee of the Month awards, Daisy awards, and High Fives. But VHA leaders express frustration at their inability to effectively reward positive engagement and performance. For example, retention bonuses for specialists require VISN approval in some cases: “Our Director manages nearly a half-billion-dollar budget, yet can’t approve a \$20,000 retention bonus” for a hard-to-replace specialist.

When poor conduct occurs, the disciplinary process is perceived as lengthy and intensely difficult: responding to a conduct issue can take up to one to two years, with multiple steps requiring careful documentation, multiple parties, and time. This has a direct impact on the Veteran as poorly performing individuals will remain on the front lines or be involved in their care for a long time. This process is further explored in Section 10.

9 Physician Alignment

9.1 Summary

This report defines physician alignment as the degree to which physicians in an organization are aligned with the goals of their organization (Betbeze, 2014).

To understand this alignment, or lack thereof, it is necessary to look at the mindsets and behaviors of the physicians as they relate to the overall goals and objectives of the organization. Findings of the study are:

- Physicians are represented on key committees, but communication often breaks down, resulting in disenfranchisement of the provider base.
- While financial rewards are not key motivators for physicians at VHA, access to research funding and work/life balance are available at VHA and are often more compelling.
- Several current structures and processes in place within VHA do not allow for effective physician alignment.

Throughout this section, we draw on insights shared during interviews with VHA leaders as well as data from the OHI survey (VHA interviews, 2015; VHA OHI Survey, 2015). Unless otherwise cited, direct quotations are from VHA interviews and survey data are from the OHI survey. We also draw on various other primary source data and cite them as appropriate throughout the section.

9.2 Findings

9.2.1 Physicians Are Represented on Key Committees, But Communication Often Breaks Down, Resulting in Disenfranchisement of the Provider Base

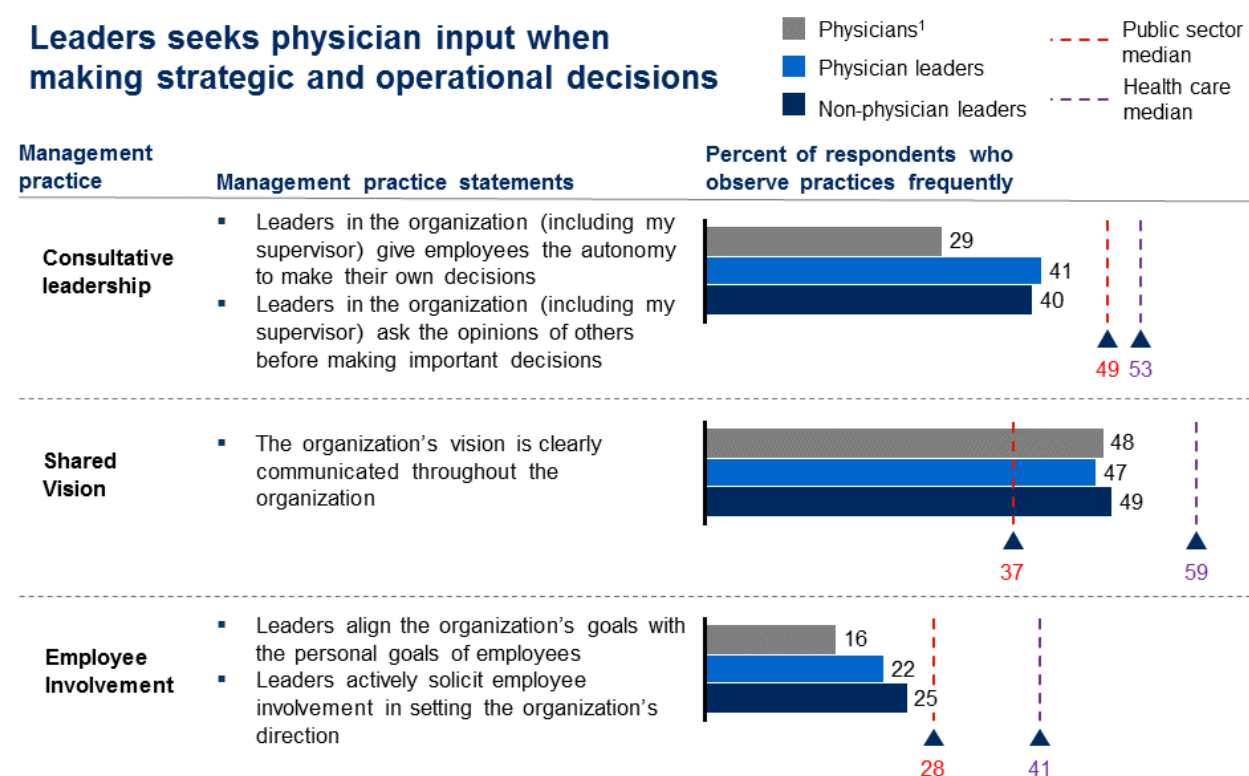
Leaders throughout the different levels of VHA routinely seek the input of physicians and other providers when setting organizational goals and policies. There are physicians on many of the major policy-setting committees at the VAMC, VISN, and VHACO levels. For example, at the VHACO level, there is a Chief of Staff Advisory Committee to the VA Principal Deputy Under Secretary for Health, which is a direct conduit for VAMC Chief Medical Officers to VHACO leadership (VA, VA Functional Organizational Manual, 2014). There is physician representation on VISN-level committees, including the Research Service Line Committee, the VISN Compliance Committee, and VISN-level Pharmacy and Therapeutics (P&T) Committees, to name a few. At the VAMC level, there are physicians on the Research and Development (R&D) Committee and VAMC Pharmacy & Therapeutics (P&T) Committees (VA website). In the interviews we conducted, Chiefs of Staff at the Medical Centers routinely made comments such as:

- “We have physician representation on all of the committees.”
- “Leadership definitely seeks physician input.”

- “Front-line MDs have a 2-year rotation on the Strategic Planning Board, and quarterly-rotating non-voting positions on the Resource Board.”

While there is physician representation on key committees, the OHI indicates that physicians not in leadership roles feel their input is less sought after than that of physician leaders and non-physician leaders. This is reflected by lower scores on consultative leadership and employee involvement [Figure 9-1]. Consultative leadership and employee involvement practices lag both public sector and health care benchmarks.

Figure 9-1. Physician Input



¹ Demographics are split as follows: Physicians: Physicians not in executive or manager role (N=878); Physician leaders: Physicians in an executive or manager role (N=125); Non-physician leaders: Non-physicians in an executive or manager role (N=1,328)

SOURCE: VHA OHI Survey 2015; Public Sector Benchmark (N=47,159, no. surveys=27); Health Care Systems and Services Benchmark (N=40,437, no. surveys=33)

A close look at the outcomes related to communication measures found in the OHI shows a disparity between the way leaders perceive they are communicating and the way physicians feel leaders are communicating back with them [Figure 9-2]. Notably, physicians not in a leadership role report low scores on “open and trusting” and “knowledge-sharing.” This disconnect suggests that leadership does an inconsistent job of subsequently articulating the organizational goals back to physicians. Neither leadership nor physician representation on these committees communicates effectively back to the physician base. The communication begins but may stop short of a rich, two-way dialogue. Even though physicians may be represented on key committees, “there are silos between clinicians and leadership,” and these

communication breakdowns can lead to a sense of disenfranchisement and a lack of engagement of the broader physician and provider base.

Figure 9-2. Clear Articulation and Communication to Physicians

OHI indicates leadership does not always clearly articulate organizational goals to physicians



¹ Demographics are split as follows: Physicians: Physicians not in executive or manager role (N=878); Physician leaders: Physicians in an executive or manager role (N=125); Non-physician leaders: Non-physicians in an executive or manager role (N=1,328)

SOURCE : VHA OHI Survey 2015; Public Sector Benchmark (N=47,159, no. surveys=27); Health Care Systems and Services Benchmark (N=40,437, no. surveys=33)

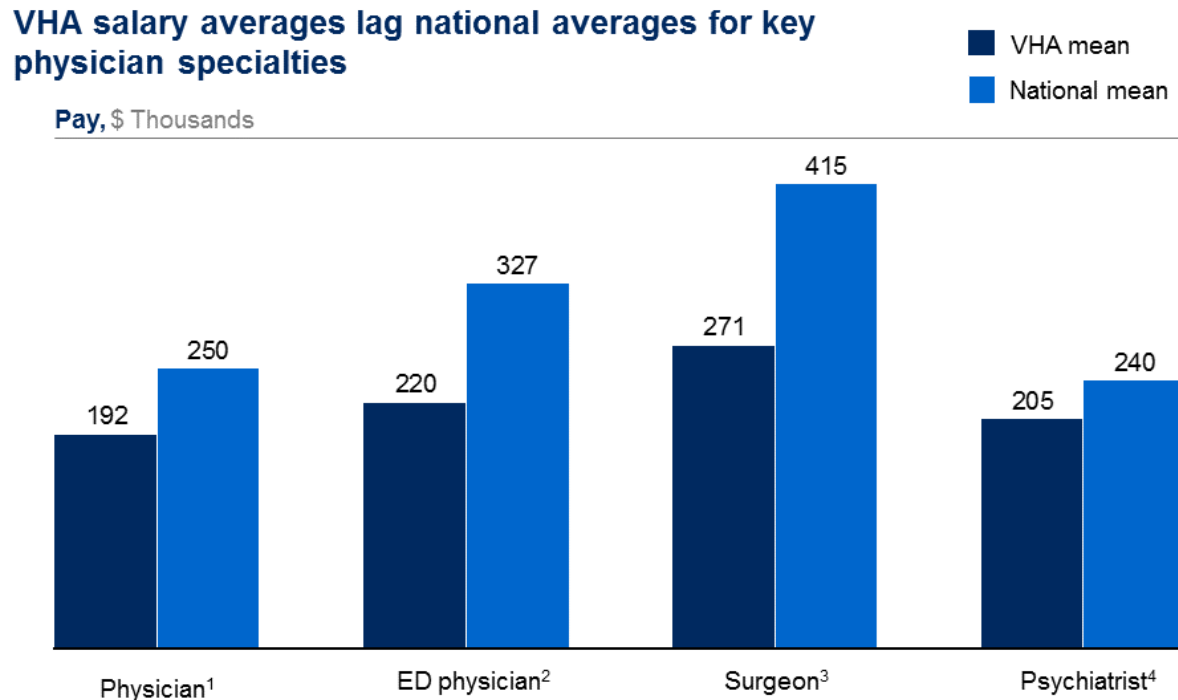
9.2.2 While Financial Rewards Are Not Key Motivators for Physicians at VHA, Access to Research Funding and Work/Life Balance Are Available At VHA and Are Often More Compelling

Within health care systems, frequently used levers to drive physician alignment include financial incentives (salary, bonus, productivity pay), work/life balance incentives, access to research and funding, and academic affiliations and their accompanying prestige and clinical teaching opportunities. Though VHA is not able to offer competitive financial incentives, the other levers are being used more successfully.

In terms of financial rewards, the current salary structure for physicians does not provide tremendous incentive. Salaries for VHA physicians are not commensurate with those outside

VHA. As **Figure 9-3** shows, VHA mean pay, even with recent Title 38¹² restructuring allowing more competitive compensation for physicians, is still significantly below benchmark.

Figure 9-3. VHA and Private Sector Physician Salaries



1 Based on pay rates from VHA Healthcare Talent Management Office for internal medicine physicians, benchmarked against MGMA data for general internal medicine physicians

2 Based on pay rates VHA Healthcare Talent Management Office for emergency medicine physicians, benchmarked against MGMA data for emergency medicine physicians

3 Based on pay VHA Healthcare Talent Management Office for general surgeons, benchmarked against MGMA data for general surgeons

4 Based on pay VHA Healthcare Talent Management Office for psychiatrists, benchmarked against MGMA data for general psychiatrists

SOURCE: VHA Healthcare Talent Management Office (2015); MGMA (2014)

While VHA is not able to provide commensurate salaries, there are other reinforcing mechanisms that VHA has at its disposal to both recruit and retain physicians. Numerous interviews with Chief Medical Officers at both the VISN and VAMC levels revealed that “VHA is the place to come for work/life balance.” In addition to the better lifestyle, there is “less paperwork” because “physicians don’t have to deal with various insurance companies and the headaches that come with all that paperwork.” Others have cited the trend toward physician practice acquisition by provider systems as a reason they favor employment at VHA. Leadership at 75 percent of VAMCs at which site visits were conducted said the prospect of a better work/life balance was a top reason why physicians chose employment at VHA. This incentive, however, is in danger of being lost, some interviewees explained, as more and more metrics being pushed down from VHACO are forcing physicians to “treat the metric and not the patient.” The increase in the number of “boxes physicians are being forced to check,” including

¹² Title 38 is a federal classification for health care professionals and covers a range of clinical professions at VHA.

through clinical reminders on CPRS,¹³ is proving to be onerous and a disincentive and is perceived by physicians to be getting in the way of providing patient care (VHA interviews, 2015; see Assessment B for additional detail).

VHA is also able to attract and retain physicians because of its academic affiliations. A number of physician leaders explained their interest in both teaching and direct patient care: “Physicians come here because they want to teach and see patients.” Most VAMCs are actively involved in the teaching of medical students and residents, and physicians enjoy the privileges that come with academic appointments at their affiliated medical universities. According to VA’s Office of Academic Affiliations, “in 2013, 40,420 medical residents, 21,540 medical students, 253 Advanced Fellows, and 1,397 dental residents and dental students received some or all of their clinical training in VA. Of its 152 VA Medical Centers and six independent outpatient clinics (IOCs), 124 hospitals and three IOCs have affiliation agreements with 130 of 141 allopathic Accredited Medical Schools and 22 of 29 osteopathic medical schools for physician education” (VA Office of Academic Affiliations). With these affiliations, VA is the nation’s largest integrated provider of health care education and training for physician residents.

The opportunity to conduct both clinical and bench research is another motivator for physicians, and here again VHA is well-positioned. Physicians “seek out VHA because it is often easier to get research projects funded.” Additionally, the research arm of VHA is set up in a way that allows “principal investigators to reapply for funding less frequently than they would need to at a university hospital.” VHA’s research budget is entirely intramural, affording only VHA physicians the opportunity to apply for grants. Notably, VHA investigators have won three Nobel prizes and seven Lasker awards (VA Office of Research and Development).

Other nonfinancial rewards routinely seen in high-performing organizations include formal rotational programs for aspiring leaders and leadership development programs. Currently, there are no formal rotational programs for physicians found within VHA. While there are formal leadership development programs, budgetary and travel restrictions placed on VHA have greatly reduced the availability of in-person programs.

9.2.3 Several Current Structures and Processes in Place Within VHA Do Not Allow for Effective Physician Alignment

In a 2011 study of over 1,400 physicians, training and resources ranked second only to compensation as a factor that would influence them to change their behavior (Kumar et al., 2011). As such, when assessing the alignment of physicians and hospital leadership and what is needed to influence change, resources available to physicians need to be considered. Physicians within VHA routinely commented “we don’t have enough space” and “in the private sector, I would have at least two exam rooms.” Other challenges cited include inefficient scheduling practices and clinical support staff, as well as challenges around IT and buying supplies. This

¹³ Computer Patient Record System

perceived lack of resources leads to frustration for providers (see Assessment B for additional detail).

10 Accountability

10.1 Summary

In this report, accountability is defined as “when one individual is answerable to another individual or organization for work (a goal-oriented behavior), resources, results and/or services” (Dive, 2008).

Accountability encompasses two elements: responsibilities for which one is held accountable, and authority and decision rights to fulfill these responsibilities.

It should be noted that while Assessment L uses a broad definition of accountability, interviews reflect that the term “accountability” is often interpreted within VHA more narrowly to mean firing or disciplinary action.

In determining to what degree VHA leaders are held accountable and whether VHA leaders have the authority to fulfill their accountabilities, study findings are as follows:

- VAMC leaders understand that they are accountable for every aspect of a Medical Center as experienced by patients, employees, oversight entities, and external stakeholders.
- For each area for which VAMC leaders are held accountable, an increase in hierarchical control intended to mitigate risk has constrained leaders’ requisite authority.
- While VHA employees believe they are individually held accountable, the perceived difficulty of the termination process decreases the practice of holding VHA employees accountable.
- VHA senior leaders are held less accountable through termination than other federal agency senior leaders.

10.2 Findings

10.2.1 VAMC Leaders Understand That They Are Accountable for Every Aspect of a Medical Center as Experienced by Patients, Employees, Oversight Entities, and External Stakeholders

In reviewing position descriptions, and supported by interviews, VHA leaders view themselves accountable for nine distinct areas within a Medical Center: employee experience, culture, operational excellence, fiscal stewardship, Veteran experience, facility matters, compliance with directives, physical safety, and external affairs (USAJobs, 2015). And while this list is expansive, it is well understood by leaders and employees throughout VHA. One Medical Center Director described a feeling held by many of those interviewed: “In a role like ours, you are, in essence, accountable for everything and to anyone.” A senior VHA official added, “There’s no going back now. With all the attention in the past year, the Directors are the public face of VA in their community.” The implication is that the local VAMC Director is the single point of contact for the Veteran and the local community.

10.2.2 For Each Area for Which VAMC Leaders Are Held Accountable, an Increase in Hierarchical Control Intended to Mitigate Risk Has Constrained Leaders' Requisite Authority

A VA Medical Center Director position description includes the provision that a Director “has full delegated line authority to accomplish all of the medical center’s missions” (USAJobs, 2015). In both perception and practice, however, this written expectation of delegated authority does not match reality; instead, it is replaced by a fragmented environment with numerous internal and external entities possessing or competing for control. While this arrangement may have served VHA in years past, expanded control to mitigate perceived political risk has exacerbated the situation to the point where it directly conflicts with the challenges of today’s environment – including changing demographics, priorities, and pressures. The new and changing needs of today’s Veteran call for flexibility and clear decision rights in support of the mission that VHA leaders do not currently possess.

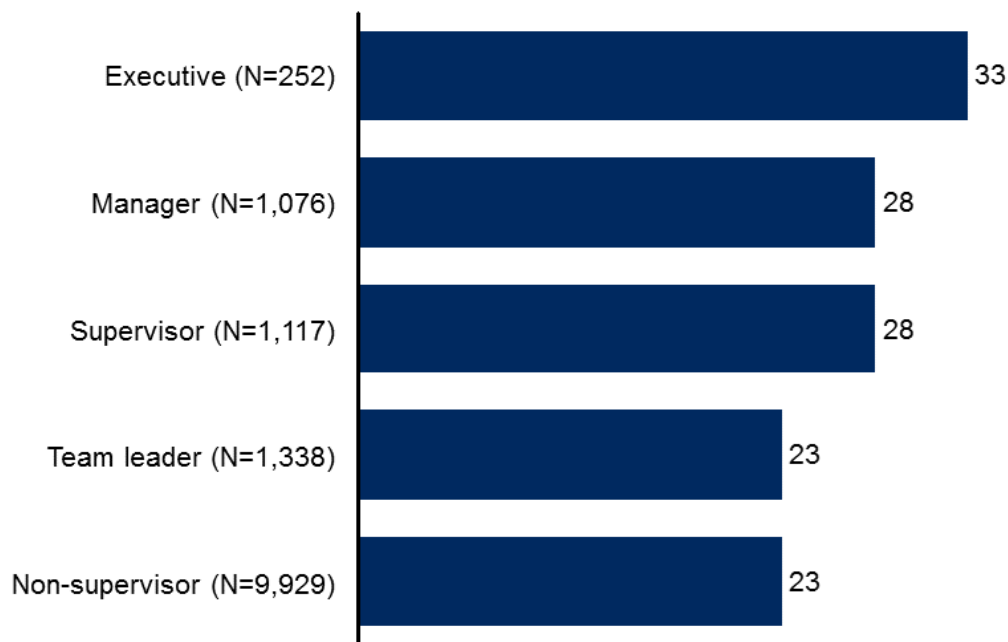
This is represented in **Figure 10-1**, as just 33 percent of VHA executives believe that employees in the organization have sufficient authority to make decisions. In less senior roles, this decreases further.

Figure 10-1. Decision-Making Authority

Only one in three VHA executives believes employees have sufficient authority, and this decreases as level of responsibility decreases

Percent of respondents who frequently observe the following behavior:

“Employees within the organization have sufficient authority to make decisions”



SOURCE: VHA OHI Survey 2015 (N=13,712)

Meanwhile, ownership and accountability are heavily fragmented across entities within the system, which helps to explain VAMC leaders' belief about lack of full authority. This is illustrated in **Figure 10-2**.

Figure 10-2. VAMC Accountabilities

Entities with authority for VAMC accountabilities

Area for which VAMC is accountable	VAMC	VISN	VHACO	VACO	Union	Congress	Other
Employee experience	✓				✓		
Culture	✓	✓	✓	✓	✓	✓	✓
Operational excellence	✓	✓	✓				
Fiscal stewardship	✓	✓	✓			✓	
Veteran experience	✓	✓	✓				
Facility	✓	✓	✓	✓	✓	✓	
Compliance with directives		✓	✓	✓	✓	✓	
Physical safety	✓	✓					
External affairs		✓	✓			✓	✓

SOURCE: VHA interviews, 2015; USAjobs VAMC job descriptions

There are at least three areas where authority is fragmented to such a degree in practice that the ability of VAMC leaders to meet expectations is compromised: operational excellence; fiscal stewardship; and compliance with directives. In each of these areas, the flexibility required of today's operating environment also requires more decision-making authority at the VAMC level than VHA's current approach permits.

- Operational excellence.** Performance targets are set by VHACO and filtered through each VISN, generally four to six months into a program year. As of spring 2015, in the middle of Q2 of the fiscal year, many VAMCs visited had yet to receive them. And yet, at the end of each fiscal year, facilities are accountable for meeting these targets, having had far less than the full year to achieve them. While VAMC leaders are accountable for operational excellence, their ability to customize performance measures or prepare for implementation is limited by their lack of authority, while the time available to achieve this target is compressed by delayed communication of targets. As one Director explained,

“There are new measures every year and they become the center of attention, until the next measures are set.”

- **Fiscal stewardship.** After appropriations are made by Congress, a VAMC budget is generally determined by VHACO through a funding formula (Veterans Equitable Resource Allocation, or VERA) that flows General Purpose funding through VISNs, and Specific Purpose funding often directly to Medical Centers. Though definitions of General Purpose and Specific Purpose funding have changed significantly, the funding coming through Specific Purpose has grown and become more fragmented, which limits local flexibility to direct resources where most locally relevant. This topic is explored further in Section 13.
- **Compliance with directives.** Communications from Congress, VHACO, and VISNs extend beyond advisory frameworks to step-by-step directives and govern many aspects of operating a Medical Center. Compliance with these directives – and welcoming accompanying audits and site visits by all stakeholders – are a core accountability of Medical Center leadership. This absorbs management attention and restricts the flexibility needed in operating environments of differing complexity. Of the “operate-by-directive” environment, one clinician leader told us: “It is very much a rule by ‘You shall’ edicts – I am told the exact number of people I will hire and the jobs that they will do – even if I don’t have a need for the policy or the people.” There is often more focus on the rule than the intended outcome.

10.2.3 While VHA Employees Believe They Are Individually Held Accountable, the Perceived Difficulty of the Termination Process Decreases the Practice of Holding VHA Employees Accountable

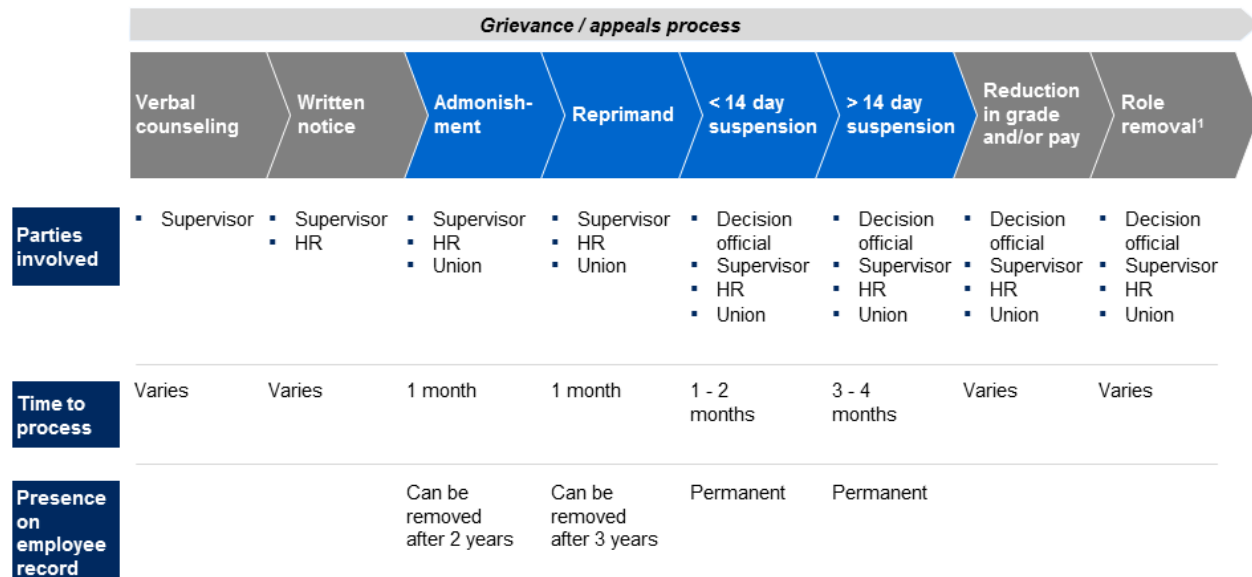
While accountabilities are clear, the ability to hold employees responsible for meeting their accountabilities is perceived as a challenge in VHA. The Organizational Health Index Survey reveals that fewer than half of employees believe employees are held accountable for results.

There are many ways in which people can be held accountable, ranging from well-defined performance expectations for each role, to clear links between performance, incentives, and consequences, to periodic progress check-ins, to progressive discipline around adverse events. Discussions with employees throughout VHA revealed that the discipline process – up to and including removal from the agency when appropriate – is a primary contributor to the perceived difficulty of holding employees accountable. Through a “progressive discipline” process, steps mandated by federal law and OPM regulations, further detailed through VA policy, and negotiated with unions, in practice require a minimum of eight months to terminate an employee for poor performance or misconduct, and often much longer (VHA interviews, 2015; VA Handbook). As one clinician told us, “We are asked to do so much. The discipline paperwork is where I cut corners – the process is just too much. That means that I’m unable to let go of employees. I just give up after a while.” Other employees felt alone in the process: “It’s so complicated. I wish HR would help us more rather than fight us.” This perception contributes to lower accountability for performance and misconduct – both believed and, as detailed below, practiced in VHA [Figure 10-3].

Figure 10-3. Progressive Discipline

VHA progressive discipline process requires at least eight months and often extends well beyond a year

Sample progressive discipline ladder, Title 5 employees



¹ Could include reassignment or removal from federal service

SOURCE: VHA interviews, 2015; VA Handbook

As an illustration, the standard progressive discipline ladder for Title 5 misconduct issues includes verbal counseling, written notice, admonishment, reprimand, short suspension (under 14 days), long suspension (longer than 14 days), reduction in grade and/or pay, and role removal. Many of these steps require union notification periods and documentation submitted by the supervisor and approved by the supervisor's manager as well as the Decision Official (e.g., VAMC Director) in the more advanced stages of the process. Some steps, by multiple interviewees' accounts, can take two to three months. This process, developed in partnership with unions, is carefully designed and clearly documented. However, following this process in reality has proven immensely difficult for two major reasons. First, supervisors feel very much at risk of retaliation and the various counter accusations that can be started. Second, given the high workload, unlikely chance of timely resolution, urgent needs of patients, and perceived variable support from HR, supervisors often choose to spend the incremental hour with patients or doing work rather than addressing personnel issues. In effect, the return on time spent regarding personnel issues does not appear to be worth the investment of time and associated risk.

One result of this is that low-performing employees may stay in the system far longer than ideal, which puts an extra burden on and hurts the morale of high-performing employees. In

some cases, leaders have resigned themselves and chosen to not even begin the disciplinary process, instead deciding to carry on as-is, despite sub-optimal conduct or performance:

- “The slow termination process is a morale killer for high performers.”
- “OK, I give up, I work shorthanded.”

The progressive discipline process, often cited as labor-intensive and ineffective, leads to very limited accountability for low-performing employees and lowers employee morale overall. As described previously, this has a direct impact to the Veteran as poorly performing individuals will remain on the front lines or be involved in their care for a long time. The real or perceived lack of HR support in the termination process forces management to navigate complex employee discipline requirements alone, which leads to many giving up.

Business leaders explain:

- “We don’t make it welcoming from the very start. Time delays. Meaningless paperwork.”
- “To discipline someone, you have to leave a paper trail, and document. You have to work through labor. You have to be really careful. A lot of people won’t even bother.”

And HR personnel concur: “If you don’t document perfectly, you’re back to square one.”

In spite of these challenges, some persist through the lengthy and sometimes seemingly arduous process. We heard at least three such examples during our interviews, from leaders who had pursued the progressive discipline process through to conclusion and explained they would do it again if the need were to arise again (VHA interviews, 2015).

10.2.4 VHA Senior Leaders Are Terminated for Performance Less Than Other Federal Agency Senior Leaders

While accountability for performance takes many forms, from requiring a simple response to spurring large changes, termination is one form rarely used by VHA. Federal personnel data show that VHA senior leaders – specifically, VAMC Directors, VISN Network Directors, and some VHACO staff who are all members of the Senior Executive Service (SES) – are held accountable through termination for discipline or performance less frequently than are their peers in federal agencies. VA ranks last among all Cabinet-level agencies in SES termination, with just one termination in the five years between FFY2010 and FFY2014¹⁴ [Figure 10-4]. It is unknown how many SES were effectively terminated by being directed to retire, demoted, or reassigned.¹⁵ As a point of reference, in this same time period, other agencies on average terminated SES employees for discipline or performance at a rate 10 times that of VA. Three SES terminations in Arizona, Alabama, and Pennsylvania in 2014 (Washington Post, 2015) indicate a potential change in this pattern and are not included in presently available data.

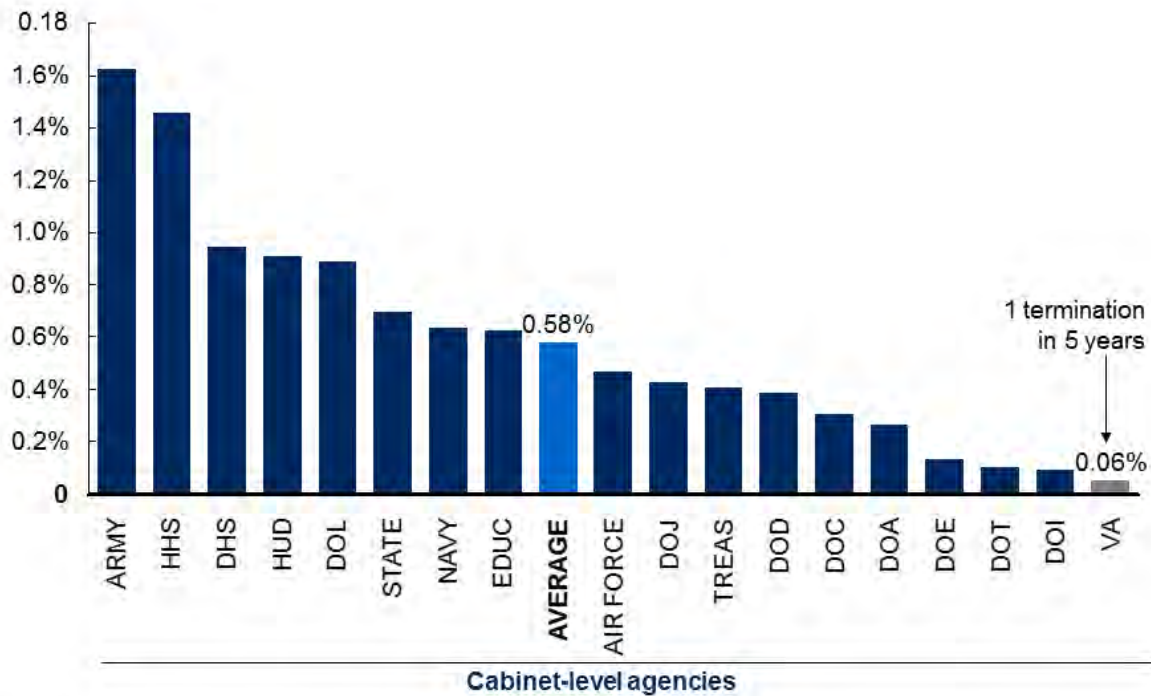
¹⁴ Federal Fiscal Year (FFY) runs from October through September.

¹⁵ Anecdotally, early retirement, removal from SES ranks, and reassignments do occur for performance reasons; however, quantitative data are not available.

Figure 10-4. SES Termination

Federal agency SES terminations for discipline / performance

Percent of all SES in agency; FFY2010 – FFY14



SOURCE: OPM FedScope – Separations and Employment Trends reports (FFY2010 – FFY14)

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11 Performance Management

11.1 Summary

This report defines performance management as the formal use of clearly defined qualitative and/or quantitative metrics or assessments used to track the performance of an activity, organization, or individual, and the comparison of performance for different activities, organizations, or individuals (adapted from Camm and Stetcher, 2010).

The performance management cycle, a continuous loop of target-setting, performance-tracking dialogues and rewards, provides a useful reference for evaluating performance management processes at both the operational and individual levels.

In determining how well its performance management processes help VHA leadership achieve its mission, the study findings are as follows:

- Hundreds of operational performance measures overwhelm leaders and this, combined with limited transparency and inconsistent data availability, makes it difficult to focus on what is most important.
- Individual performance management processes are hindered by targets inconsistent with the VHA mission, delayed implementation, lack of meaningful dialogue, and limited rewards.

Throughout this section, we draw on insights shared during interviews with VHA leaders as well as data from the OHI survey (VHA interviews, 2015; VHA OHI Survey, 2015). Unless otherwise cited, direct quotations are from VHA interviews and survey data are from the OHI survey. We also draw on various other primary source data and cite them as appropriate throughout the section.

11.2 Findings

11.2.1 Hundreds of Operational Performance Measures Overwhelm Leaders and This, Combined With Limited Transparency and Inconsistent Data Availability, Makes it Difficult to Focus on What is Most Important

Operational performance management can be analyzed through the lens of the performance management cycle: targets, tracking, reviews, and rewards [Figure 11-1]. In doing so, each segment reveals opportunities for improvement.

Figure 11-1. Performance Management Process

The Performance Management Process



Clear targets that advance mission

VHA tracks several hundred performance measures at the facility level. A common response repeated consistently by interviewees when asked about operational performance metrics was: “There are too many.” One Director described his perception of VHA’s approach to setting performance measures as: “If 50 metrics are good, 100 must be better.” There is widespread recognition of this overabundance of metrics and the need to simplify: as one leader articulated, “Performance goes down when there are more measures. We need to get away from the spreadsheet and closer to the action. Facilities need coaches – not just shaking a finger and saying, ‘Can’t miss this.’”

With 382 measures today in its 10-N National Performance Measures Report provided by interviewees, VHA is not setting clear, actionable targets (10N NPRM, 2015). Instead, leaders are left to figure out for themselves the most critical metrics against which to measure their part of the organization. As one Director told us, “We choose the most important ones to focus on and leave the rest alone.” In attempting to increase control over outcomes through measurement, VHA has inadvertently created an environment in which leaders are selecting which measures are most rational instead of which measures – either those existing or those not yet adopted by VHA – help advance the mission.

This was not always the case. As former Under Secretary for Health Dr. Ken Kizer described in a 2014 article in the *New England Journal of Medicine*:

The performance-measurement program – a management tool for improving quality and increasing accountability that was introduced in the reforms of the late 1990s – has become bloated and unfocused. Originally, approximately two dozen quality measures were used, all of which had substantial clinical credibility. Now there are hundreds of measures with varying degrees of clinical salience. The use of hundreds of measures for judging performance not only encourages gaming but also precludes focusing on, or even knowing, what’s truly important. (Kizer and Jha, 2014)

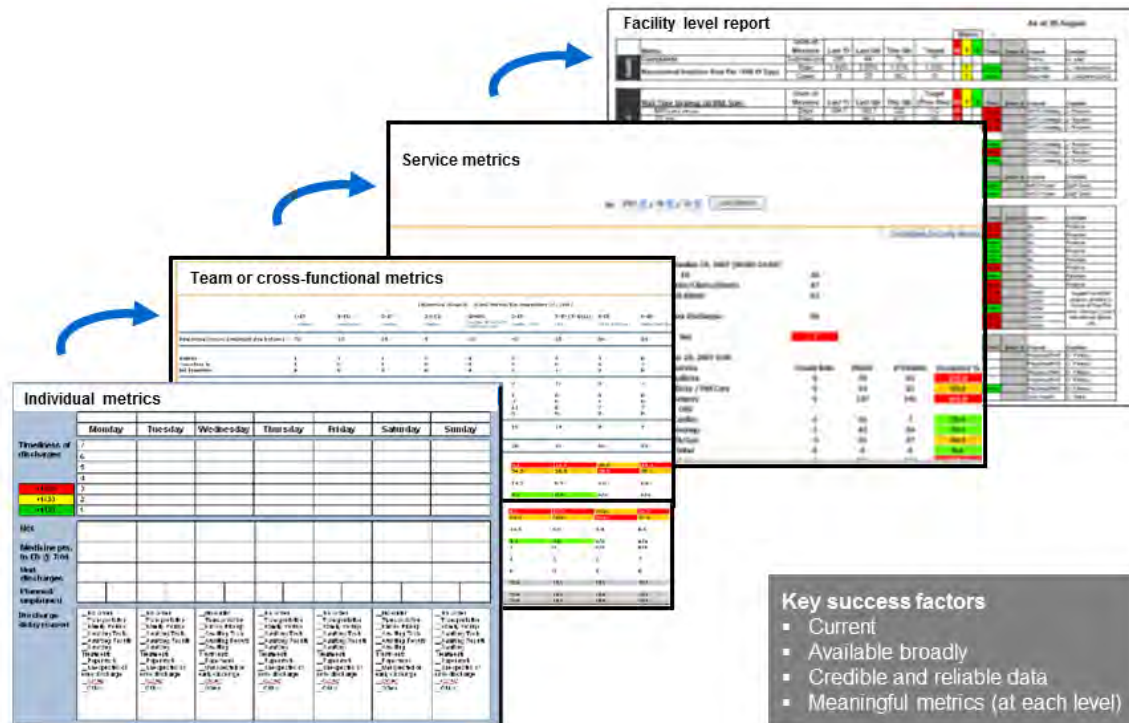
In addition to numerous clinical process and performance measures, each VHA program office has specialized targets that are built into performance plans. These have contributed to the even greater number of performance metrics. At present, these include measures for homelessness reduction, diversity hiring, and contracting, among many others. This mission-expanding metric proliferation, in particular, has the dual effect of fragmenting focus for leaders and reducing control over their local activities.

At many high-performing private sector hospitals, targets are balanced in support of the mission, with a limited number of key metrics focused in the following areas that collectively contribute to organizational performance: quality, patient satisfaction, operational excellence, finance, and human resources. Metrics cascade logically across levels of the organization, and roll up into an overarching scorecard **[Figure 11-2]**.

Figure 11-2. Metrics

Each set of metrics is rolled up into the next level of metrics

ILLUSTRATIVE
OF BEST PRACTICE



In contrast, VHA's catch-all approach extends well beyond these focused areas. In addition, VHA does not cascade targets consistently, and in many cases they are not precise and actionable.

In addition to having too many metrics, there are also places where VHA is noticeably silent. For example, VHA does not place sufficient emphasis on finance and human resources, with measures in the 10-N performance measures report related to finance and HR limited to contracting and hiring goals. This inconsistency hampers transparency.

In recent years, VHA has promoted a new, more focused set of measures – Strategic Analytics for Improvement and Learning (SAIL). Issued quarterly, SAIL measures 36 areas over 10 categories including: access; inpatient/outpatient performance; mortality; adjusted length-of-stay; customer satisfaction; readmission; adverse events; efficiency; ambulatory care/sensitive conditions hospitalizations; and mental health. While it has not replaced the existing hundreds of performance measures, SAIL is more consistently aligned to the VHA mission in that its quality measures focus on core operations. While not comprehensive enough to be the sole set of metrics used by VHA leaders (for example, financial and human resources measures are not included, and the number of measures is likely still too high to be actively managed by leadership), SAIL represents a foundation upon which improved target-setting could be built.

Performance tracking

The views, opinions, and/or findings contained in this report are those of the assessment team and should not be construed as an official government position, policy, or decision.

The large number of performance measures makes it difficult to effectively track performance. Performance management approaches commonly used in private sector settings are not feasible given the number of measures currently used today at VHA. The proliferation of measures leads to the perception that, as one Director told us, “If everything is a priority, then nothing is a priority.”

There are bright spots, however. Use of visual reports during daily performance meetings by senior leaders is increasing, for example in Jackson, MS. This serves to increase transparency and helps leaders and employees focus on key metrics. The SAIL report is another good example of clear visual reporting, communicating results in a visual that quickly informs leaders how they are performing against their peers. Other facilities, such as the Lexington, KY VAMC, use a systems redesign approach to focus their employees on critical improvement initiatives. Lexington has also folded the introduction of standardized huddleboards – visual management systems – into Service Chiefs’ performance standards. Meanwhile, VISN 3 (Bronx, NY) leaders spoke of bringing a productivity ethos to the physicians there through the introduction of relative value units (RVUs). Initially, RVUs were heavily resisted by physicians, and it took three years of consistent effort to overcome that resistance. Explained one leader: “We started with no one believing anyone had the right to look at them [doctors]. Got a few willing people to sign up. We then made it very visual and simple. Next we spent a lot of time talking and changing the ‘you don’t understand’ mindset. As each learned to make a little improvement, the program began to get buy-in. We presented results to leadership periodically and celebrated successes. Over the past year Brooklyn really stepped up. The Director was a champion and helped drive the effort. Transparency was key. The impact was that the cost/RVU went down 24 percent. Wow.” Building more transparency along these lines could be very helpful to leaders on the front line.

Effective review meetings

One of the primary practical roles of the VISN is to ensure performance targets are negotiated with VHACO and are being met at the VAMC level. This leads to regularly scheduled meetings with VAMC leadership to review binders of performance reports and frequent requests for detailed corrective action plans when a measure is “in the red.” Because target-setting is often delayed and new initiatives are introduced regularly, a consistent theme of these meetings was described by one VAMC leader as “explaining why we would not make the measure this year but hoping that making progress toward it would be good enough.”

In practice, progress reviews generally focus primarily on the weakest performance measures and are not used as problem-solving sessions. Rather, the expectation is that the VAMC will create an improvement plan and present it to the VISN for approval. Coaching and best practice-sharing as a way to bridge performance gaps does occur, but not with regularity. This contributes to a commonly held perception that metrics are used to identify weak performers, rather than to help drive performance excellence.

Reward and recognition

As facility funding is formula-based, there are not direct relationships between facility performance and financial reward (that is, greater access to resources) at the operational level.

Indirect rewards such as continued affiliations with academic hospitals, reputational enhancement (especially for those looking to advance their career), and increased freedom to focus on improvement instead of corrective action do exist. One reward, a publically available quintile status from the SAIL report, was frequently mentioned as an important source of pride. There is opportunity to simplify performance management to focus more on the mission, drive performance excellence, and promote continuous improvement.

11.2.2 Individual Performance Management Processes Are Hindered by Targets Inconsistent With the VHA Mission, Delayed Implementation, Lack of Meaningful Dialogue, and Limited Rewards

Analyzing individual performance management through the same lens of the performance management cycle – targets, tracking, reviews, and rewards – reveals significant gaps.

Targets

VHA leaders' individual performance targets are linked to operational targets. This linkage, in principle, should promote clarity. In practice, however, three characteristics of the VHA process limit the setting of clear, actionable targets.

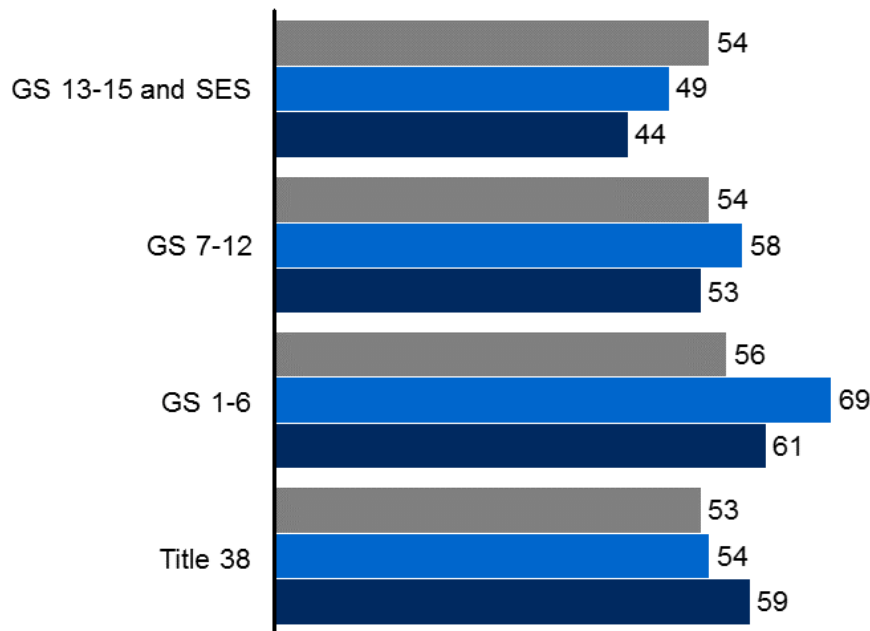
First, delays in setting operational targets at the national and VISN levels result in downstream delays for VAMC individual leaders and their direct reports. Targets and new initiatives are late by as much as five months into the program year. VAMC interviewees report: "We cannot expect our staff to achieve performance expectations by the end of the year when there is ramp-up and learning associated with new metrics." These delays contribute to a belief held by many employees that VHA does not set explicit targets for operating performance [Figure 11-3].

Figure 11-3. Operational Target-Setting

Nearly half of VHA employees do not believe that explicit targets exist for operating performance

Percent of respondents who frequently observe the following behavior:
“Each unit of the organization has explicit targets for its operating performance”

■ VAMC
■ VISN
■ VHACO



SOURCE: : VHA OHI Survey 2015 : VAMC (N=10,134); VHACO (N=1,207); VISN (N=603)

Second, the proliferation of special programs has created more confusion for leaders. For example, a Hepatitis C initiative was the only measure listed under “leading change” for one senior leader; and for another leader, breast and cervical cancer screening was the first priority categorized under “business acumen.” Leaders are careful to note that these care priorities are important, but that measurements are implemented in ways that can confuse priorities.

Third, metrics are presented as individual in nature, both to a facility or across facilities, and then to the individuals who work in a facility. Instead of acknowledging that, in many cases, an entire facility contributes to successful achievement of the mission, metrics are assigned to functional owners and split along clinical/non-clinical roles. The volume of metrics described above contributes to this lack of team-based measurement.

VHA’s Blueprint for Excellence indicates that VHA is currently working to align individual performance plans to the organization’s overall goals.

Performance-tracking

Despite the volume of metrics, and the general lack of standardization, performance-tracking is a relative strength of VHA. A mix of centralized and homegrown reports, dashboards, and other tools is used to monitor performance and drive excellence on a daily basis. When standardized

tools either do not exist or do not fully meet a need, Medical Centers create solutions that work best for their teams. For example, one physician leader in the Durham, NC VAMC provides flashcards with metric methodology and current performance to front-line staff to help employees understand how their actions influence a performance measure and to let them know where they stand. There is an opportunity to share these approaches more broadly throughout the system.

Progress reviews

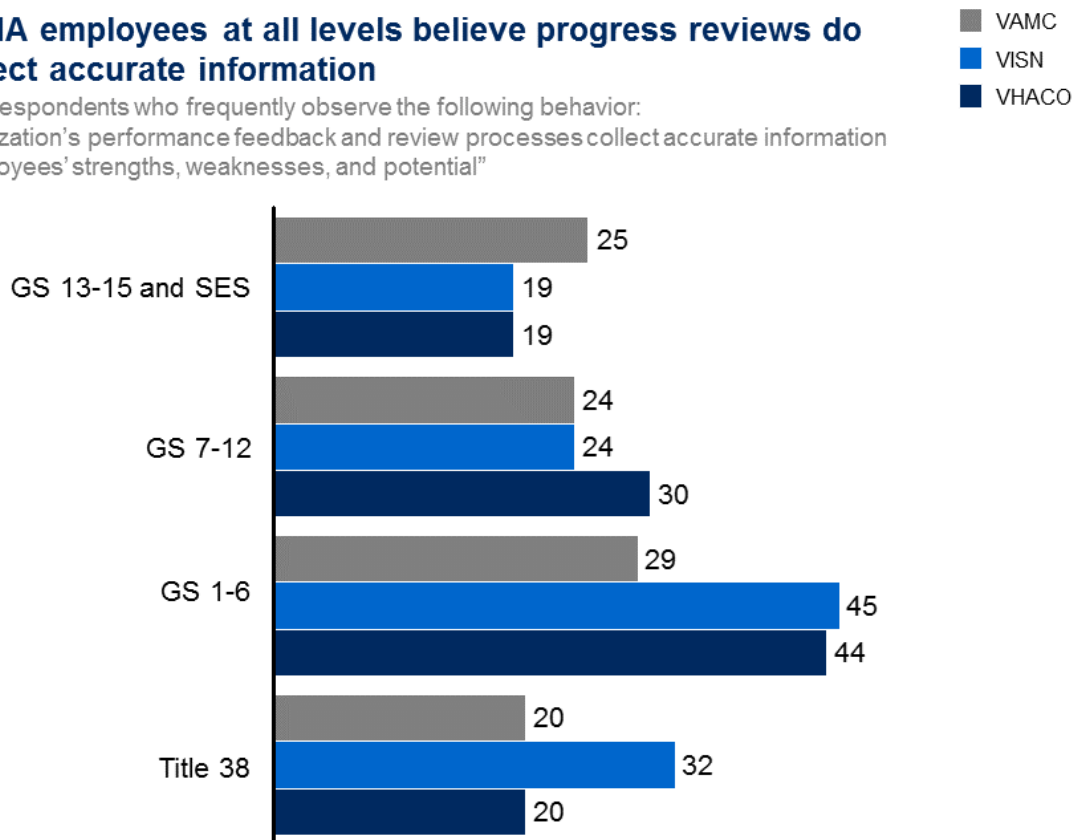
Individual performance reviews follow a rigid structure mandated by federal statute, VA directive, and labor bargaining agreements. Formal reviews typically occur once a year, with ratings between 1 to 5 provided to employees. Some HR officials report that midyear reviews are becoming more normal in their facilities as well.

Having this structure in place provides a solid foundation, but as Figure 11-4 shows, employees do not believe that performance feedback and review processes are effective. Performance dialogues between management and employees that are timely and actionable, and help identify and advance developmental needs, are not a norm at VHA. “I haven’t had a performance review in years,” said one senior leader. In recent months, this has impacted many senior leaders in VHA: as of June 2015, 20 percent of SES positions have their 2014 ratings deferred, pending the results of investigations or other actions, and, for some cases, without explanation for the deferral (VA, Accountability Fact Sheet, 2015; VHA interviews, 2015).

Figure 11-4. Progress Reviews

Most VHA employees at all levels believe progress reviews do not collect accurate information

Percent of respondents who frequently observe the following behavior:
“The organization’s performance feedback and review processes collect accurate information about employees’ strengths, weaknesses, and potential”



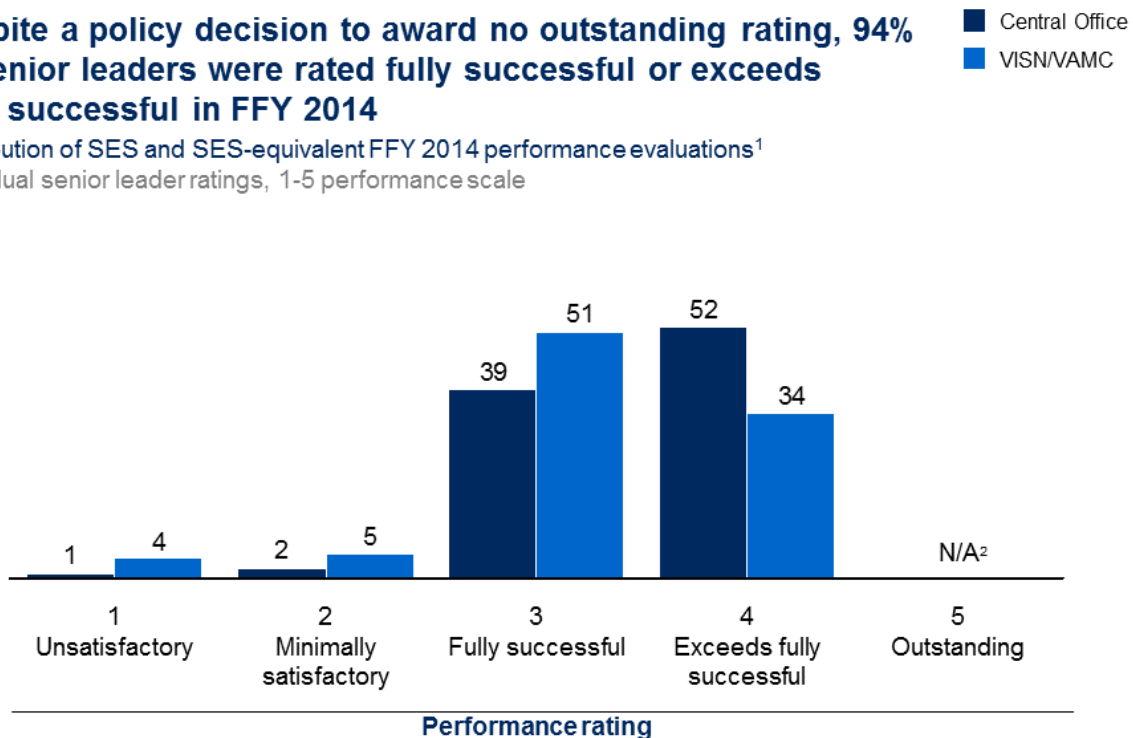
SOURCE: : VHA OHI Survey 2015 : VAMC (N=10,134); VHACO (N=1,207); VISN (N=603)

For senior executives at VHA, performance ratings, the primary feature of the review process, suffer from a common shortcoming: imperfect distribution biased toward high performance [Figure 11-5]. Every VHA senior executive received a “Fully Successful” or higher rating from FY2010-2013 (VHA Workforce Management and Consulting Office). Increased scrutiny and a decision to award no “Outstanding” ratings in FY2014 has done little to change this pattern, as 94 percent of VHA senior executives were provided a “Fully Successful” or higher rating. The incongruity of this situation grows when reviewing Office of Personal Management criteria for “Minimally Satisfactory,” one level below “Fully Successful.” “Minimally Satisfactory” performance for executives is defined as follows: “Contributions to the organization are acceptable in the short term...the executive generally meets established performance expectations, timelines and targets...” While not praiseworthy, this standard – a 2 out of 5 on the rating scale – appears relevant for more than a few executives in any organization. This rating inflation diminishes the credibility of a key tool of VHA’s review process and suggests ratings reform is needed, or another way of evaluating performance is needed, or both.

Figure 11-5. Performance Rating Distribution

Despite a policy decision to award no outstanding rating, 94% of senior leaders were rated fully successful or exceeds fully successful in FFY 2014

Distribution of SES and SES-equivalent FFY 2014 performance evaluations¹
Individual senior leader ratings, 1-5 performance scale



¹ Among all employees who have received a rating as of March 2015 (70% of all SES and SES-equivalent)

² No 5 (Outstanding) ratings were given in FFY2014

SOURCE: VHA Workforce Management and Consulting, 2015

Rewards and recognition

The clearest weakness for VHA revealed in the OHI was financial incentives. Nearly all employees at each level of the organization, and particularly senior leaders, believe that financial incentives are not attractive enough to motivate employees [Figure 11-6]. Only one in 10 senior leaders believes VHA provides attractive financial incentives. At the most senior level at VHA, for example, SES salaries are capped at \$183,300 (OPM, 2015). In practice, the average non-Title 38 VAMC Director salary is \$166,900, ranging from an average of \$176,800 at the most complex VAMCs, to \$157,400 at complexity level 2 facilities and \$162,300 at complexity level 3 facilities (VHA Healthcare Talent Management Office, 2015).¹⁶ In comparison, private sector hospital CEOs often enjoy high six-figure or seven-figure compensation packages.

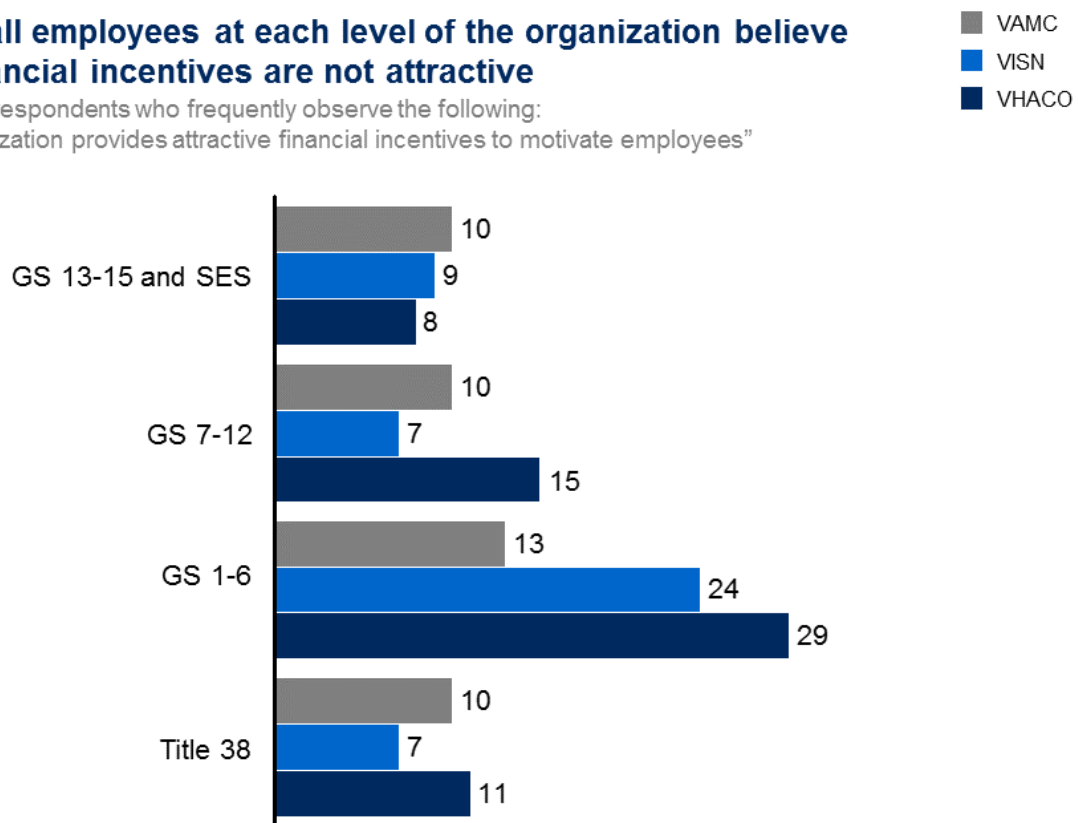
¹⁶ Title 38 employees, including seven Title 38 VAMC Directors, are not included in SES salary cap and VAMC Director salary averages.

Figure 11-6. Financial Incentives and Motivation

Nearly all employees at each level of the organization believe that financial incentives are not attractive

Percent of respondents who frequently observe the following:

“The organization provides attractive financial incentives to motivate employees”



SOURCE: : VHA OHI Survey 2015 – VAMC (N=10,134); VHACO (N=1,207); VISN (N=603)

VHA faces challenges in offering rewards that are more motivating to employees. A consistent theme in speaking with HR chiefs reveals that limited rewards encourage front-line employees to switch jobs frequently to transition to higher-grade opportunities: “Employees are constantly striving toward the next grade, without much regard to the position. It is the only way in their eyes to be properly rewarded, even if they are not fully aware of the increased responsibility a higher-grade position brings with it.”

Bargaining agreements steer managers toward standardized treatment of employees, and, as has been established elsewhere in this report, compensation policies are less flexible compared to private sector counterparts, although this is less pronounced in some Title 38¹⁷-eligible occupations where locally competitive salary flexibility is allowed (see Assessment F for additional detail). It should be noted that VA is pursuing a legislative remedy in its most recent federal budget request to expand Title 38 salary flexibility to non-clinical leadership positions, although Congress has yet to act on this request (VA, 2016 Congressional Submission, 2015).

¹⁷ Title 38 is a federal classification for health care professionals and covers a range of clinical professions at VHA.

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12 Reform Readiness

12.1 Summary

This report defines reform readiness as the ability and willingness of an organization to embrace and drive change.

Successful change in an organization requires clarity around the need for change, clear signaling by leadership that change is important, and resulting employee buy-in and support from leadership to help implement and sustain the change.

In determining the degree of reform readiness found within VHA, study findings are as follows:

- Employees believe that VHA leaders do not effectively encourage or embrace new ideas.
- Change at VHA happens, but only rarely, takes a very long time to permeate the organization, and often stalls.
- Many change efforts come from Central Office and do not fully engage employees in the change process.
- Change efforts are rarely given the necessary time or support to ensure success.

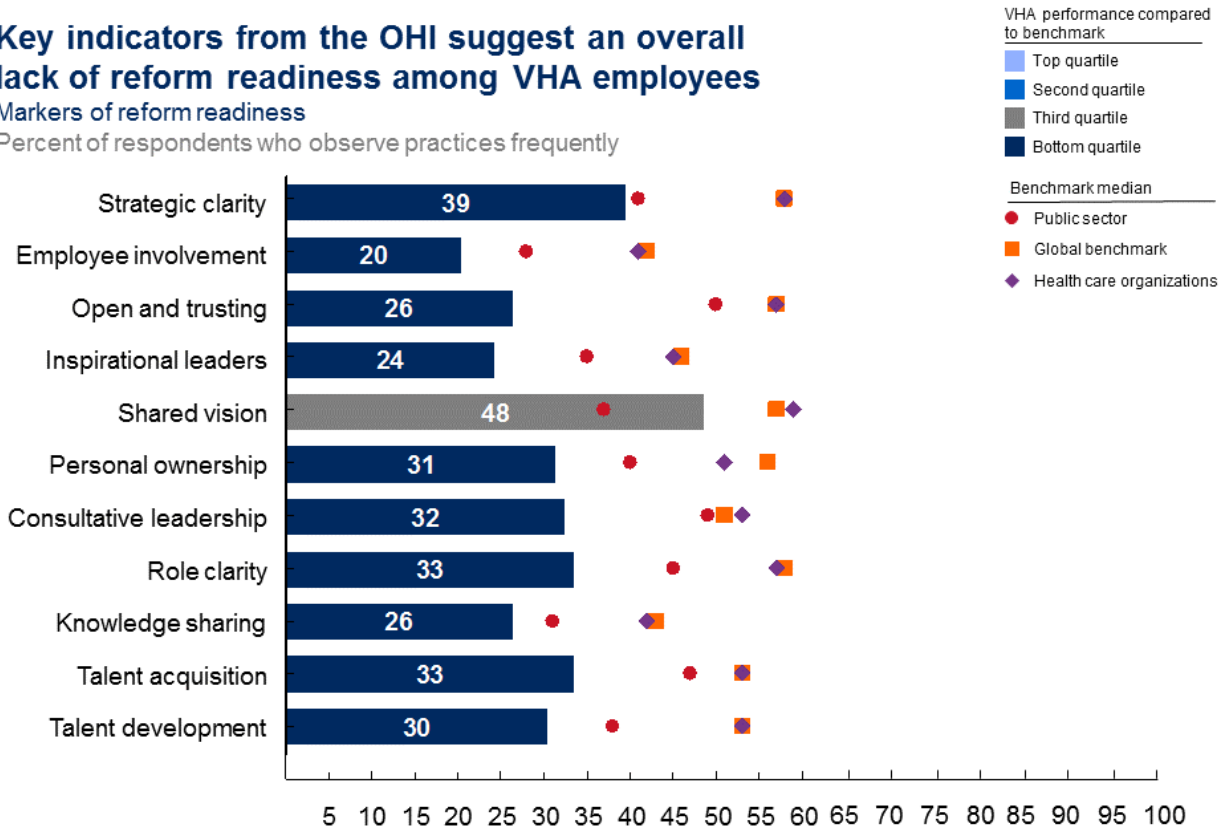
The OHI measures of reform readiness **[Figure 12-1]** show the VHA system is demonstrably less ready for change than either comparable public sector organizations or other health care systems.

Figure 12-1. Reform Readiness

Key indicators from the OHI suggest an overall lack of reform readiness among VHA employees

Markers of reform readiness

Percent of respondents who observe practices frequently



SOURCE: VHA OHI Survey 2015 (N=13,712); Global Benchmark (N=1,259,322, no. surveys=737); Public Sector Benchmark (N=47,159, no. surveys=27); Health Care Systems and Services Benchmark (N=40,437, no. surveys=33)

Throughout this section, we draw on insights shared during interviews with VHA leaders as well as data from the OHI survey (VHA interviews, 2015; VHA OHI Survey, 2015). Unless otherwise cited, direct quotations are from VHA interviews and survey data are from the OHI survey. We also draw on various other primary source data and cite them as appropriate throughout the section.

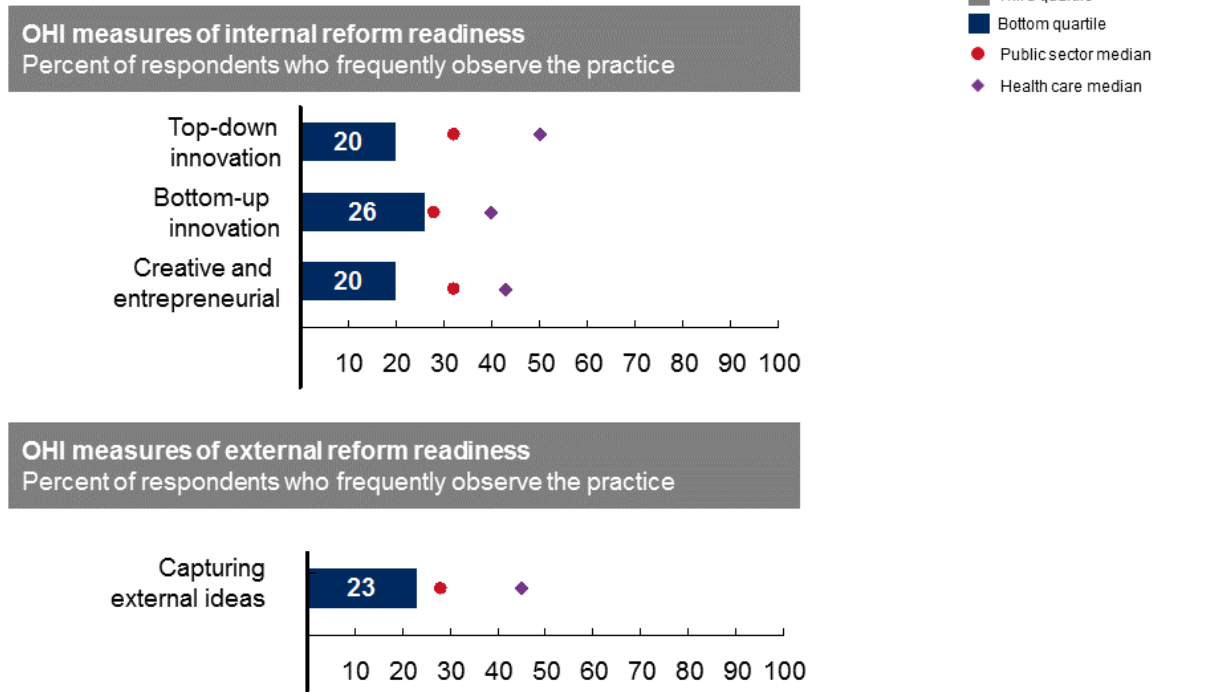
12.2 Findings

12.2.1 Employees Believe That VHA Leaders Do Not Effectively Encourage or Embrace New Ideas

Analyses of OHI data indicate that current VHA leadership is not readily receptive to either external or internal suggestions for change. Measures of internal reform readiness and external reform readiness at VHA are bottom quartile, lower than both public sector and health care median performance [Figure 12-2].

Figure 12-2. Receptiveness to New Ideas

VHA leadership is not overly receptive to internal or external ideas



SOURCE: VHA OHI Survey 2015 (N=13,712); Public Sector Benchmark (N=47,159, no. surveys=27); Health Care Systems and Services Benchmark (N=40,437, no. surveys=33)

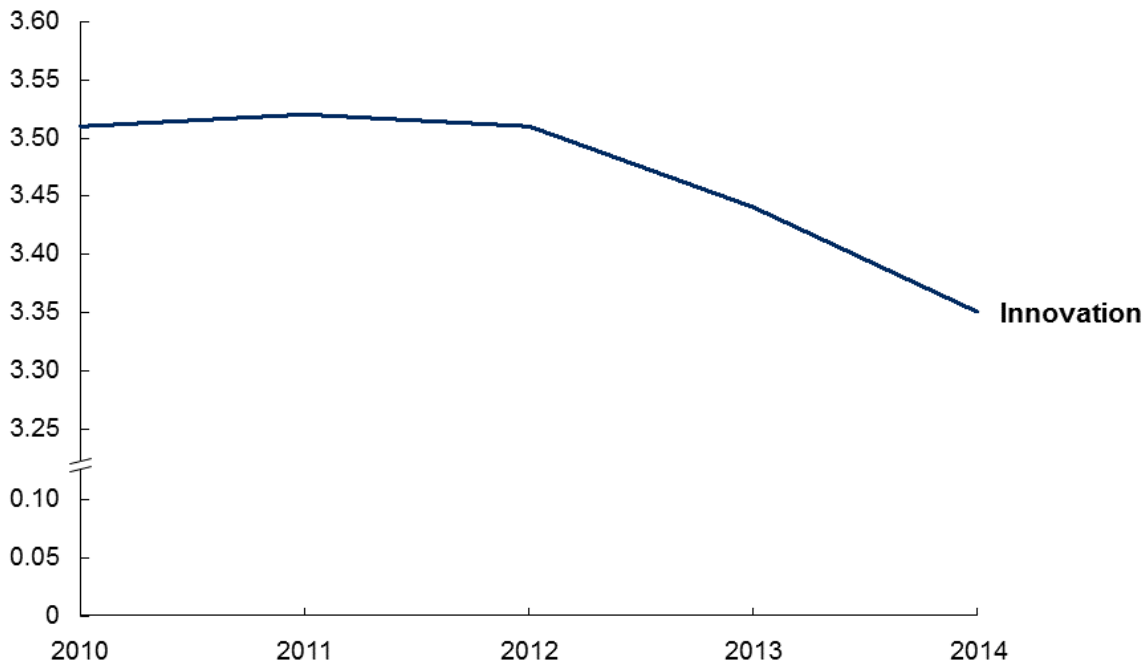
Data from the recent VA All Employee Survey (AES) convey a similar lack of readiness for change [Figure 12-3]. Over the last four years, there has been decreasing agreement with the AES question: “New practices and ways of doing business are encouraged in my work group.” Scores have gone from a high of 3.54 in 2011 to 3.38 in 2014. Though a small decrease in absolute terms, it represents one of the five largest declines in recent years (VA, All Employee Survey, 2014).

Figure 12-3. Innovation

VHA employees have felt decreasing encouragement to innovate

AES measure of innovation¹

3-Neutral 4-Agree



¹ AES Question: "New practices and ways of doing business are encouraged in my work group"

SOURCE: VA, All Employee Survey, 2014

Interviewees describe an organization where employees are not encouraged to bring up new ideas. Sometimes this comes from system fatigue, other times from being told not to raise one's hand, and still other times employees may be hesitant to speak up for fear of retaliation, or a burden of added work. This environment dampens the internal generation of new ideas. The impact on the Veteran is significant, as this directly impacts the improvement of their care through reduced spread of best practices or new ideas. VHA's Blueprint for Excellence lists "Provide a Psychologically Safe Environment for Employees" as a key transformational action. It is unknown what the impact of VHA's actions will be on improving psychological safety.

12.2.2 Change At VHA Happens, but Only Rarely, Takes a Very Long Time to Permeate the Organization, and Often Stalls

As a large federal agency, VHA is slow to change. The sheer size of the organization makes change difficult, and several leaders spoke of a "stasis" that keeps people from really exploring the "evolution of the status quo." Change efforts often take years, not months, and can be limited by rules and competing priorities:

- "So many obstacles and rules that it's really hard to change."

- “It takes five to seven years to get a program up and running. We are not a nimble organization.”
- “Institutional resistance in getting change to happen – no coordinated approach to combat this.”
- “One of the problems when you look at VHA: there is an effort to start [something] and then six months later another initiative. Some groups lapse because they are taken over by others... VA is pretty poor on implementation. Some energy, then another theme overtakes it.”

The short tenures of many VAMC directors also add to the challenge. Over the last five years, the VAMC director turnover rate has been around 10 percent, but this figure excludes leaders who leave one Director position to assume another Director position at another facility, which would increase the rate above the 10 percent figure (VHA Healthcare Talent Management Office, 2015). In several instances we heard leaders explain that their staff “needed stable leadership, needed people who cared about this organization, who were going to stay for a while.” Another leader explained, “We’ve had no consistency at the top. We’ve had acting directors for the last two years. There is no permanent body. We need that consistency. The directors come in with new ideas, but they don’t have the time to implement anything.”

12.2.3 Many Change Efforts Come From Central Office and Do Not Fully Engage Employees in the Change Process

There are many sources of potential change for an organization, but when bottom-up innovation and external orientation are less developed (as referenced in **Figure 8-5**) there is an over-reliance on top-down directives for change. At VHA, one of the most common source for change is Central Office (VHACO or VACO) requiring the organization to do something, with or without essential resources, time to react, and support. The growth of Central Office Program Offices, explored in greater detail in Section 13, has exacerbated this.

This “command-and-control” approach to change is difficult to embrace and hard to implement: “When change comes, getting that implemented effectively is a challenge.” It is also difficult to react to requests before additional requests arrive: “New policies or expectations come down, and before there is time to learn them and get comfortable, there’s something else.” This emphasis on command and control misses the opportunity to truly engage employees and field leaders in driving, absorbing, and embracing change. As one VHACO leader explained, “VHA needs to take a field-up process to make change happen... The greatest strength we have is our workforce, and we are blowing it.”

There are, however, areas where innovation is thriving on a facility-level scale. For example, the Portland, OR VAMC encourages innovation by creating a culture that values innovation “at the top,” creates space and time for smart people to get together and collaborate, and has clear communication, all of which supports what some employees explained as a “culture of yes.” Against a backdrop of resistance to change and fear of retaliation, these pockets of excellence are proof that innovation can still thrive in some areas of VHA.

12.2.4 Change Efforts Are Rarely Given the Necessary Time or Support to Ensure Success

The current VHA operating environment is not conducive to change because change efforts are often not given the necessary time or support to ensure success. External stakeholders – such as Congress, VSOs, and the media – are expecting quick-reaction timing and want to see fast results. This near-term pressure does not engender support of broader transformation efforts that take time to unfold and take root, which in turn does not set up a longer-term platform for sustained transformation. Meanwhile, it can be difficult for VHA leaders to focus on driving the change, as they are often distracted by “putting out fires.” This is also exacerbated by a lack of stable leadership at the very top due to the frequent rotation of political appointees. Across government agencies, short tenures of political appointees can limit their effectiveness, as “people in the agency can simply wait them out if they want to resist the change”. As described earlier Congress authorized the U.S. Internal Revenue Service Reform and Restructuring Act of 1998 (RRA 98), which granted Charles Rossotti a five-year term that provided Rossotti the opportunity to fully implement the IRS transformation (Rainey and Thompson, 2006). Meanwhile, in the high performing health systems the team visited, we also generally saw longer tenures for top executives – an average of 10 years across four system CEOs.¹⁸ Though a small sample size, this suggests that leaders at these high performing organizations have a long enough runway and a stable foundation from which to lead their organizations effectively.

¹⁸ Analysis of senior leadership tenure of chief executives at Cleveland Clinic, Geisinger, Kaiser Permanente, and Virginia Mason (n=4).

13 Supporting Infrastructure

As we undertook this assessment focused on the eight elements identified in the Veterans Choice Act, three other critical issues emerged: overall operating model, budgeting and resource management, and human resources – recruiting in particular. Although these were outside the scope of Assessment L, these elements are critical underpinnings of how the system works and how leaders operate within VHA, and we felt it important to acknowledge them. We did not do a full assessment of each of these areas; these are initial findings that we hope can help address the supporting infrastructure challenges identified during our work on Assessment L.

Throughout this section, we draw on insights shared during interviews with VHA leaders (VHA interviews, 2015). Unless otherwise cited, direct quotations are from VHA interviews. We also draw on various other primary source data and cite them as appropriate throughout the section.

13.1 Overall Operating Model

From the point of view of leaders and employees, the VHA organization is intensely, unnecessarily complex – it is becoming harder and harder to “get things done” as the number of new policies and oversight continues to grow. This difficulty results from a fragmentation of authority and overlapping responsibilities. There is a lack of clarity around roles and responsibilities across VAMCs, the VISNs, and VHACO. The fragmentation and silos exist across the system and within each tier of the organization (e.g., VACO, VHACO, VISN, VAMC). Authorities, leadership development, contracting, and financial and budgeting controls lack clarity and coordination across entities and levels, resulting in duplication, communication breakdowns, and responses too slow to meet the needs of the mission. It is also important to recognize that VA exists in a context influenced by a number of stakeholders, including for example Congress, Veterans, VSOs, OMB and OPM.

During the course of the assessment the team identified four main findings:

- VHACO has grown rapidly in the past few years and fails to coordinate, integrate, or prioritize the policies it directs the VISNs and VAMCs to follow.
- The VISNs’ ability to manage and support their regions is heavily hampered by resourcing restrictions and direct VHACO control over VAMC operations.
- The VAMCs’ operating model suffers from powerful silos, which prevent an effective end-to-end mission focus.
- VA’s increasingly top-down management style, coupled with poor prioritization and the external political environment, result in a lack of clarity around strategic direction, reactivity to external headwinds, and flawed efforts to standardize.

Before elaborating on the findings, it is important to describe the current operating model and its origins.

13.1.1 Background and Context

VHA currently operates across three major organizational levels: Central Office (VHA and VA headquarters); regional headquarters (VISNs); and the Medical Centers (VAMCs). Under Dr. Ken Kizer's leadership, the VISNs were set up in the mid-1990s to create an organizational unit that was the right level to be patient-centered, facilitate collaboration across facilities, maintain long-standing relationships with local caregivers, and be small enough to be accountable for activities in that region. As Dr. Kizer explained in a recent article:

During the reforms of the 1990s, decentralization of operational decision-making was a core principle. Day-to-day responsibility for running the health care system was largely delegated to the local facility and regional-network managers within the context of clear performance goals, while Central Office staff focused on setting strategic direction and holding the "field" accountable for improving performance. (Kizer and Jha, 2014)

Many leaders we spoke with referred back to the original intent behind the operating model design and described how each layer was intended to perform the following functions¹⁹:

- **Central Office.** Set strategy and policy, perform oversight, support the field, and be a high-level interface with Congress and other government agencies
- **VISN.** Integrate operations for the region. Specifically, the VISNs allocate resource/budget allocation across facilities; identify and capture network economies of scale; bring the voice of the field to Washington and liaise with headquarters; support innovation through targeted pilots; coordinate referrals to the private sector; act as the regional interface with state- and regional-level agencies; integrate actions with VBA and NCA in the region; support contracting; and conduct performance management and oversight across the VAMCs.
- **VAMC.** Deliver care – specifically, the Medical Centers and their associated CBOCs serve as the focal point for delivery and coordination (in or out of the Medical Center) for individual Veterans. This includes coordination and billing of care done by non-VHA entities (e.g., university-affiliated hospitals). The VAMCs report up through the 21 VISNs.

13.1.2 VHACO Has Grown Rapidly in the Past Few Years and Fails to Coordinate, Integrate, or Prioritize the Policies it Directs the VISNs and VAMCs to Follow

Over the past decade, VHACO has shifted from focusing on setting direction, crafting policy, and performing oversight and performance management to a much more centralized top-down model (Kizer and Jha, 2014). As described by a VHACO official, it became a management style of "You shall do this, you shall do that. All those 'thou shalt's' – they're all piecemeal, just a bunch of disjointed tasks that don't make sense."

Currently, VHACO has a large number of Program Offices that create and monitor an array of policies, and these policies most often flow directly to the VISNs and VAMCs. The program

¹⁹ The following list is non-exhaustive and derived from VHA interviews, 2015.

offices, often under intense pressure from external stakeholders, create the policies and do not adequately coordinate or prioritize them with the other Program Offices. The number of program offices is over 100: an external website review accounts for 104 Program Offices, while an internal VHA report from earlier this spring shows 120 (VA website, va.gov). This organizational fragmentation is highlighted in the 2015 Governance Task Force Report:

For example, programs responsible for elements of patient care are now dispersed into Patient Care Services, Public Health, and the Assistant Deputy Under Secretary for Health for Clinical Operations. Another example is programs related to quality... VHA programs directed to each of [six aims for high-performance health care] are dispersed throughout the organization, with effectiveness, safety, and efficiency reporting to Quality; patient-centered care reporting directly to the DUSHOM; timeliness (i.e., clinic access) reporting to the ADUSHOM for Administrative Operations; and the Office of Equity reporting directly to the Principal Deputy Under Secretary for Health. (VA, Task Force on Improving Effectiveness of VHA Governance, 2015)

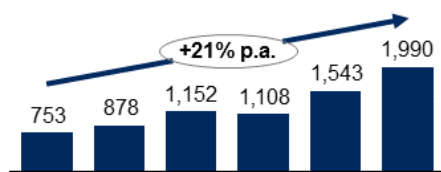
The number of people staffed to Program Offices has grown dramatically over the past five years. VHACO Program Office FTE²⁰ growth has vastly outpaced growth of the total VHA employee population and Veterans served, more than doubling between 2009 and 2014 [Figure 13-1].

²⁰ Full time equivalent

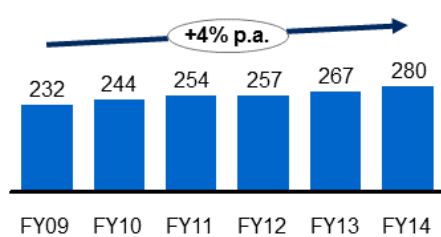
Figure 13-1. Program Office Growth

VHACO Program Office FTE growth has outpaced other VHA populations

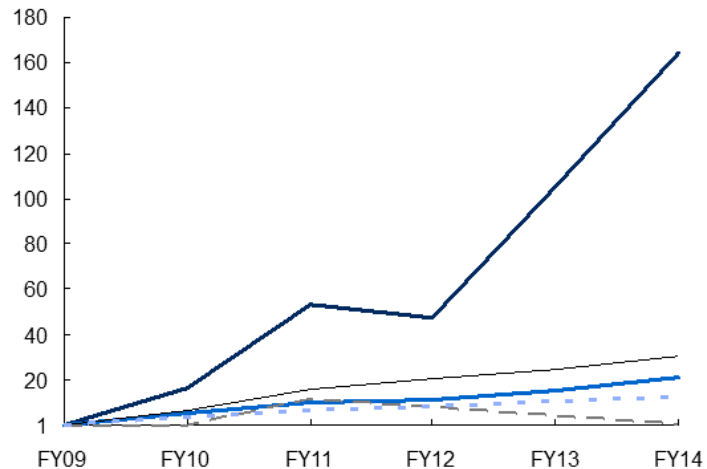
VHACO Program Office FTE¹, FY2009-FY14
FTE



VHA FTE total, FY2009-FY14
FTE, thousands



Growth of VHACO, FY2009-FY14
Growth, percent; normalized to FY09



1 Station 101 only; excludes CMOP, CPAC, Business Office, and other similar direct service programs

SOURCE: VA, Task Force on Improving Effectiveness of VHA Governance, 2015

It is difficult to benchmark the size of VHACO to private sector comparables. While the growth of VHACO may have multiple drivers during the FY 2009–FY 2014 timeframe, the overall trend of a growing VHACO is clear even when including accounting realignments from the field to Central Office.

Despite Program Office growth, there is little systematic effort to coordinate or integrate efforts and initiatives. The deliberate organizational split between operations (10N)²¹ and policy (10P)²² exacerbates this. The team could not identify any other office performing the integrating role and only the Under Secretary for Health has the requisite organizational power. One senior VHACO leader explained: “We have policy and directives. But these are revered more in Central Office than in the Field. The directives are redundant and don’t all add up. They’re updated every five years, but more as a “check the box” exercise. We don’t really focus on how they get updated, and they’re not updated in concert with each other.”

²¹ 10N is Operations and Management

²² 10P is Policy and Services

The resulting impact on Medical Centers is felt as a constant stream of changes being requested from afar, with little to no warning, context, or dialogue. These policies are not integrated into local operations and are rarely accompanied by resources or implementation support. The Medical Centers are required and held accountable to implement the various uncoordinated policy directives, often with no input provided by the individuals who will actually implement the policy. As one VHACO leader explained, “We have a bunch of policy development but no ownership for outcomes. People in the field have responsibility for execution, with no input into the strategy development.” Additional perspectives from VHA leaders both in the field and at VHACO include:

- “New priorities result in new programs. And a new Program Office in Central Office leads to a new program person in the VISN (such as homelessness or mental health). This is how we’ve grown. I don’t know that it’s the best way to do things. Every time a new initiative gets stood up, a new Program Office gets stood up. None of them ever get stood down.”
- “Every Program Office has great aspirations, but they operate in silos.”
- “VA headquarters officials issue memos and directives, with little face-to-face conversation around expectations or implementation issues. Leaders should be out in the field to see if what they develop inside the Beltway [Washington, DC] resonates. Often it doesn’t.”
- “The farther you get away from the sharp end of the stick, the more people get caught up in the bureaucracy.... One of the reasons why the bureaucracy in Washington needs to be as lean as possible is to help keep the focus on what’s important. There should be no bureaucracy beyond what’s necessary for the front-lines to do what they’re supposed to do.”
- “In Central Office, when people have an idea, they stand up a committee, which then leads to the stand-up of an office that then operates in a silo and pummels the field.”
- “Why so many [taskings and requests from Central Office]? I don’t know. It’s become a common mechanism. It comes from the VISN and every Program Office. It takes a ton of tracking. And we rarely get any feedback or follow-up on things we submit. We have a staff member who does nothing but receive action items, disburse them, and follow up. We look at the list every morning after rounds to assess what needs to be done immediately and whom we need to pressure.”

While Congress mandates parallel efforts for various initiatives, it generally does not mandate separate program offices for each initiative. Nonetheless, setting up a new program office for a new directive can be a clear indication that VHA is taking specific steps in response to a new priority. Absent focused efforts to manage these priorities in a well-coordinated way, it is not surprising that program offices have grown so dramatically.

13.1.3 The VISNs' Ability to Manage and Support Their Regions Is Heavily Hampered by Resourcing Restrictions and Direct VHACO Control Over VAMC Operations

The role of the VISN has become increasingly variable and nebulous over the past two decades. Although we did not diagnose what transpired since the VISNs were formed in the mid-1990s, the role they serve today is quite different from the original concept envisioned when the VISNs were formed.

Currently, the role of the VISN is widely variable and ill-defined. Some VISNs play a heavy compliance role, others play a consultative or support role, and some are in-between. In some cases, the VISN role is primarily one of soliciting information from VAMCs and consolidating it to respond to requests from Central Office. It is often not clear when VHACO will work through the VISN or go straight to the facilities. As described by one former Network Director, "There are no rules of engagement at all – a big frustration of mine." There are some exceptions, where more clarity exists, such as VERA funding paths. Against this context, there is a need for clearer alignment between the VISN and Central Office, and a focus on what is the right role of the corporate center.

VISNs are responsible for performance of their respective Networks, but face significant restrictions on how they can allocate money and integrate, revise, or prioritize policies flowing from Central Office. This limits the ability of the VISN Directors (and the VAMC Directors who report to them) to rapidly correct unforeseen issues or allocate resources based on localized needs. The budgetary restrictions and their effects are described in the next finding. Interviews at all levels of the VHA organization indicated that the VISN rarely is able to effectively coordinate or influence the policies coming down from Central Office. Though they play some role in filtering and streamlining information coming from Central Office, they have limited ability to shape the message or participate in the dialogue.

13.1.4 The VAMCs' Operating Model Suffers From Powerful Silos, Which Prevent an Effective End-To-End Mission Focus

VAMC personnel face a daunting challenge in their mission to deliver care to the Veteran as they must work across a multitude of organizational silos, with each silo often seeking to optimize its outcomes (or minimize its risk exposure). Three major causes for the silos are the intense compliance focus, a narrowing use of funds, and a culture that does not reward collaboration across work groups.

Except for the VAMC Director, the VAMCs we visited often lacked roles or champions who focus their efforts across the silos in order to coordinate delivery of care, and when these champions do exist, they often cited limited authority and influence over other organizational units to collaborate. Examples of the impact include the hurdles that doctors and nurses face to procure basic necessities, the length of time it can take to get a maintenance request resolved, and the difficulty in coordinating care across multiple departments. Interviews indicated that support functions (i.e., human resources, IT, or contracting) viewed complete compliance with siloed rules as success without regard to the impact on overall care delivery. The result is a model that

is very difficult to operate and pushes employees to disengage out of frustration and risk-aversion.

13.1.5 VA's Increasingly Top-Down Management Style, Coupled With Poor Prioritization and the External Political Environment, Result in a Lack of Clarity Around Strategic Direction, Reactivity to External Headwinds, and Flawed Efforts to Standardize

This combination of increased centralization, expanded size, and lack of coordination and prioritization is further complicated by the political environment in which VA operates. This landscape contributes to a lack of clarity around strategic direction, confusion around leadership priorities, and fragmentation of management attention:

- **An expanding scope of VHA activities has led to confusion around leadership priorities.** The organization's focus has expanded and shifted over time, and it is unclear what the priorities are, and unclear when they will shift again. Many leaders in the field express a desire for more strategic clarity, coordination, and support from Central Office. One former VA official expressed the urgent need for "leaner programs, clear discussions between the program and operations side, clarity over what's most important and where the energy should be focused." Other leaders expressed:
 - "Is there a clear vision of the future, agreed-upon aspects, performance outcomes, clearly communicated? No."
 - "At VA, it becomes 'Here's the next initiative. Here's the next one.' It's never clear which one is about accountability and which one is a good idea."
 - "We're drowning in policies. GAO recently told us that our policies are unclear. When you create a structure like the one we have where people's jobs are to create policies, you get what we have."
- **The external political environment complicates an already complex organization trying to fulfill its strategic direction.** Lack of clarity of direction is further weakened by Central Office's reactivity to external headwinds. This reactive stance results in "Flavor-of-the-Month" policies and taskings, which do not send clear signals to the field about what is most important. Select perspectives include:
 - "At high levels of the organization, there are no priorities, and the winds shift and people get confused."
 - "Every time they had a finding, VA's only answer was to write a directive. But that's not the only answer."
 - "VA looks at a problem, they get a hearing, it becomes public, and all of a sudden there's an entire structure to make sure this never happens again."
 - "We have a defensive posture with policies – 'just in case.'"
 - "Central Office manages everything by crisis."

- “We must react to the ‘Flavor of the Year.’ This extreme focus on a single issue takes time, attention, and resources away from the general purpose of the facility – to treat Veterans – when we still have a hospital to run.”
- “I don’t understand the role of Program Offices. Most were built in crisis. There’s never an ROI afterward.”
- **The increasingly top-down management approach has led to inconsistent and poorly implemented standardization efforts.** In some cases, the wrong things are standardized, while in others there is so much standardization and control that implementation proves difficult. And yet, many leaders recognize the value of standardization, and would like to see VHA standardize more, in the right way:
 - “Centralization and standardization – we tend to standardize everything and nothing at the same time.”
 - “VA doesn’t standardize the things it needs to at the Medical Center level and give them the authority to do those tasks and create a support model for them to do it. And so you end up with a lot of variability across hospitals. [The] same thing happens at Networks. Each Network comes up with its own set of solutions.”
 - “We need to identify key business processes that have to be standardized (like scheduling), and standardize those things ruthlessly. We need fidelity in the system to run the business. We can’t figure out what to standardize.”
 - “We still do not have a national policy on scheduling/appointments, despite all the attention. We’re coming up with our own anyway – but that is a place where Central Office could have been helpful. Where we need direction, we don’t get it.”

Leaders hold out hope that standardization can work well within this system, and Pharmacy Benefits Management (PBM) is one example of where it has worked quite well (see Assessment J for additional detail).

13.2 Budgeting and Resource Management

Throughout the course of our work and interviews, topics related to budget and resource allocation came up frequently. Our findings are as follows:

- Several challenges arise in how funding is allocated.
- Much of the support funding is outside of local control, which contributes to organizational silos and cumbersome or inefficient processes.
- Spending authorities are uneven.
- Management systems are not well integrated and data analytics capabilities are inadequate.
- The increasing share of Specific Purpose funding hinders leadership’s ability to effectively allocate resources.

13.2.1 Several Challenges Arise in How Funding Is Allocated

A number of challenges are observed with the current system. They include:

The views, opinions, and/or findings contained in this report are those of the assessment team and should not be construed as an official government position, policy, or decision.

- VERA does not keep up with shifting care priorities and patient loads.

As care priorities and the Veteran population have changed, Medical Center leaders report that the Veterans Equitable Resource Allocation (VERA) model has not kept pace with changing on-the-ground needs, as VERA is based on historic figures and does not take into account forecasted changes (VA, Veterans Equitable Resource Allocation (VERA) 2014 Handbook). This is especially challenging for facilities that are seeing significant increases in patient load. Moreover, new priorities are funded with restrictive Specific Purpose funds, each designed for a very explicit, but not always comprehensive, goal. The compartmentalization of funding reduces flexibility in how to use the resources, and some believe it has gone too far: “Rather than hold people accountable for projects, they try to fence the funds. We have 27 different appropriations.”

- Current system does not incentivize continuous efficiency improvement.

After receiving General Purpose funds from VA through VERA, VISNs first allocate a portion of the money to VISN-specific initiatives and emergency reserves. VISN-initiative funds must be reported to VACO, and emergency reserves are not allowed to exceed 1.5 percent of the total allocation. The VISN then allocates the remainder of the money to the stations (VAMCs), making adjustments between stations as needed. Through this reallocation, stations that continually operate budget shortfalls are provided for out of the surplus of other stations in the network. While this does allow for necessary adjustments (such as, expensive care in rural regions dictated by access needs), it also removes the incentive for stations to pursue cost-efficiencies. Given the history of reallocation, station leadership knows that surpluses in their own budgets could be easily redirected to accommodate shortfalls elsewhere, rather than reinvested in their own station (GAO, 2011; VHA interviews, 2015).

- VERA allocation does not take into consideration additional operating costs that result from leasing, effectively imposing a long-term penalty on VISNs that rely more heavily on leased facilities.

The allocation formula does not consider additional operating costs driven by the increased use of leased medical facilities. VERA is determined through a formula based primarily on patient volume and complexity of care. This is designed to increase responsiveness to workload changes, but also has the consequence of penalizing VISNs that rely heavily on leased facilities instead of owned properties. The operating costs, per patient, of a leased facility are higher than those of an owned facility, where capital costs are covered with an additional allocation of capital funds upfront. As VHA increasingly looks to leased properties to accommodate increases in workload, this mismatch in the VERA formula has the potential to strain the budgets of growing VISNs that are funding numerous leases out of their operating budgets (VERA 2014). (See Assessment K for additional detail.)

- Obligation targets (percent of funds allocated by certain quarter) cause projects to be prioritized based on ability to obligate/execute, rather than true need-based priority.

A major focus of VHA is meeting obligation targets throughout the year – specifically for the non-recurring maintenance (NRM) program. Because NRM funds expire within one

year, VHA has internal targets by quarter for obligation of allocated funds – for example, some VISN must obligate 80 percent of funds by the third quarter of the fiscal year. This constraint drives selection and execution of projects depending on “preparedness” to execute (for example, an off-the-shelf design project) rather than needs-based priority. (See Assessment K for additional detail.)

13.2.2 Much of the Support Funding Is Outside of Local Control, Which Contributes to Organizational Silos and Cumbersome or Inefficient Processes

Local facilities have little authority over VA-wide functions like HR, IT, and contracting. Many of the tools of leadership – managing people through human resources, ensuring employees have access to resources, materials, and facilities needed to care for the Veteran, etc. – are outside of the direct control of local leaders who rely on these processes. Mechanisms are not in place to compensate for this, service-level agreements are not widely used, and the culture in general does not engender collaboration across organizational units.

13.2.3 Spending Authorities are Uneven

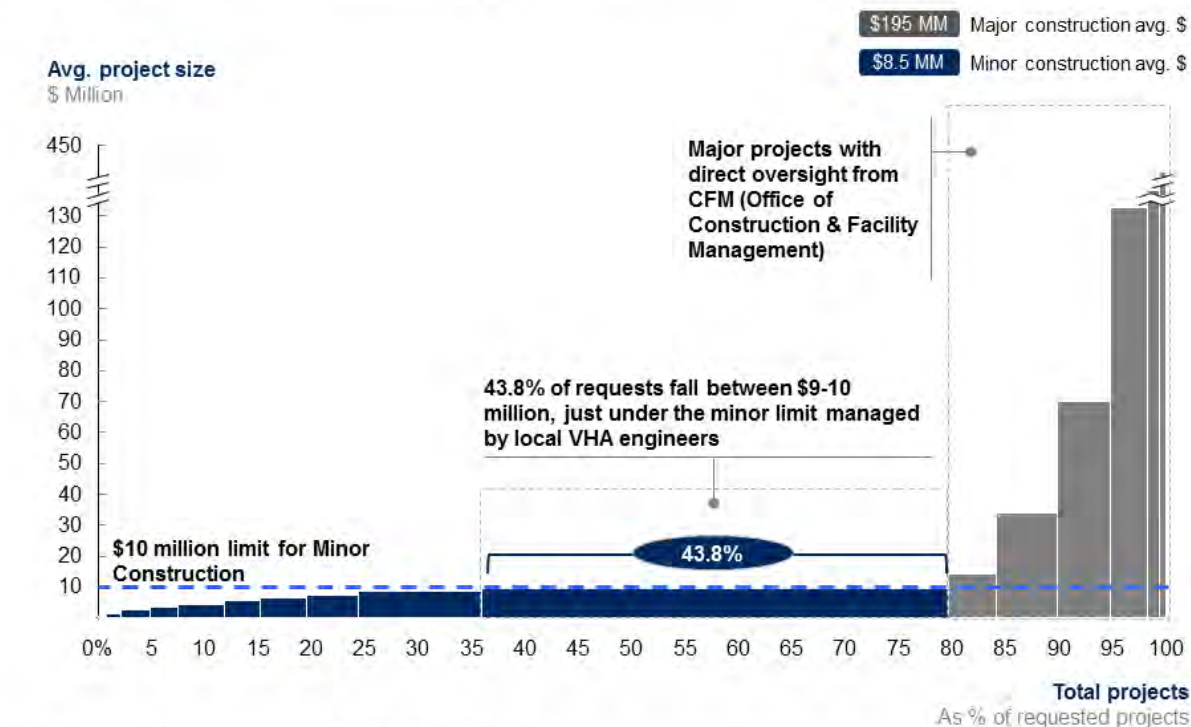
Spending authority is uneven, with many working hard to keep spend under certain dollar thresholds to avoid lengthy and uncertain approval processes.

By statute, minor projects and NRM projects cannot exceed \$10 million. As a result, most projects are consistently developed to stay just below the threshold (see Assessment K for additional detail). **Figure 13-2** illustrates this behavior in recent strategic capital investment plan (SCIP) submissions.

Figure 13-2. Breakdown of Major and Minor Projects by Project Size

Volume of project submissions directly under \$10 million Minor Construction threshold illustrates careful project packaging

Average size and number of FY16 SCIP Major and Minor Construction requests



SOURCE: FY14-16 SCIP submissions; VHA interviews, 2015

Additionally, the limit is strictly governed for in-process projects. While there is a defined process to receive a cost limit increase, that process is extremely burdensome, such that stations avoid it if at all possible, reducing or even abandoning the project if necessary. (See Assessment K for additional detail.)

13.2.4 Management Systems Are Not Well-Integrated and Data Analytics Capabilities Are Inadequate

Managers must make many major decisions without the benefit of normal business analytics. The effects are most acute in procurement and staffing. The procurement system is not integrated with the financial management system, and there is limited built-in feedback. Systems are fragmented, for example, 145-item master files and purchasing databases exist. The inventory management system does not provide actionable and relevant metrics for performance management, and data related to medical supplies and devices are not standardized and is often missing. (See Assessment J for additional detail.)

In staffing decisions, current practices and tools do not allow VHA to know whether it is consistently setting staffing levels appropriately, affecting the ability to manage resources effectively. At the most basic level, models do not exist or are not easily accessible for how to

staff a facility of a given size and complexity. One VHACO leader explained, “I don’t know how many people should be staffed in a CBOC, or a Level 1a, or a Level 3 facility.” Many service lines lack clear national staffing guidance, resulting in ad hoc methods of estimating FTE need. Resource management is often siloed by service line, resulting in inconsistent decision-making on staffing that does not always match needs. It should be noted that nursing staffing models are relatively well-developed for certain service lines, and the fact that they even exist is a great start – and there is an opportunity to take a more holistic look at staffing models to understand the skills and capabilities needed for the VHA workforce at large.

(See Assessments F, H, and J for additional detail.)

13.2.5 The Increasing Share of Specific Purpose Funding Hinders Leadership’s Ability to Effectively Allocate Resources

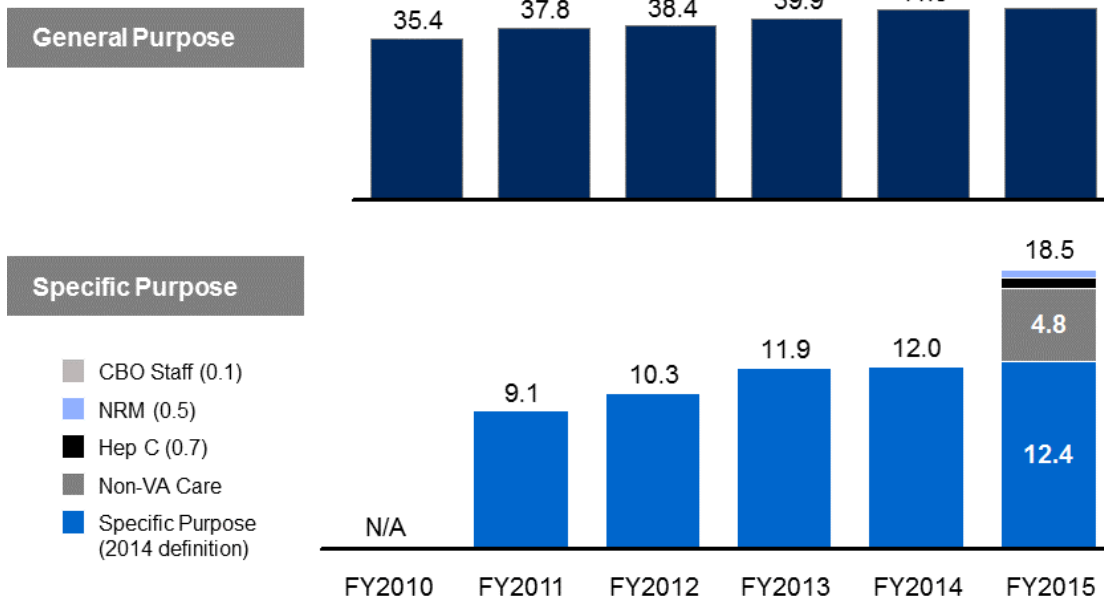
An increase in Specific Purpose funding restricts the flexibility leadership has to meet mission needs **[Figure 13-3]**. Specific Purpose funding has many restrictions placed by Congress on how it can be used, and it can be highly variable year-to-year: “There is no equitability in Special²³ Purpose programs – you never know when you’re going to get it.” In addition, once Specific Purpose is carved out first, VERA allocates the remaining General Purpose funding. VHA is required to fund Specific Purpose at the amount specified, so in a world of constrained resources it is most often General Purpose funding that comes up short. It is important to note that the definition of Specific Purpose has changed significantly in the last year, making it difficult to fully reconcile budget figures in an “apples to apples” way. Nonetheless, because of the difference in how Specific Purpose and General Purpose funding can be spent, this increase in Specific Purpose funding has a material impact on the field’s ability to adjust funding allocations to account for local needs.

²³ Special Purpose is sometimes used interchangeably with Specific Purpose.

Figure 13-3. General Purpose and Specific Purpose Funding

Evolution of General Purpose and Specific Purpose funding, FY2010-FY15

\$ Billions



1 2011-15 for Specific Purpose

2 Specific Purpose numbers for every year include new programs and program offices (e.g., Office of Informatics and Analytics, National Center for Patient Safety, Employee Education Service Center)

SOURCE: VERA 2014 Handbook, FY2015 Draft VERA Budget

The growth in FY2015 Specific Purpose funding comes from two major sources. The addition of a \$5 billion Non-VA Care line item (a provision in the Veterans Choice Act) effectively changed how that funding is managed. Before this, Non-VA Care funds were in General Purpose funding and allocated to the field through VERA. The Veterans Choice Act required that this money be allocated based on workload credits, but managed through the Central Business Office via Specific Purpose. The other major change was the addition of approximately \$700 million in Hepatitis C Specific Purpose funding. The net effect is to fence off 30 percent from leadership's control, reducing their ability to effectively direct resources to areas of most need.

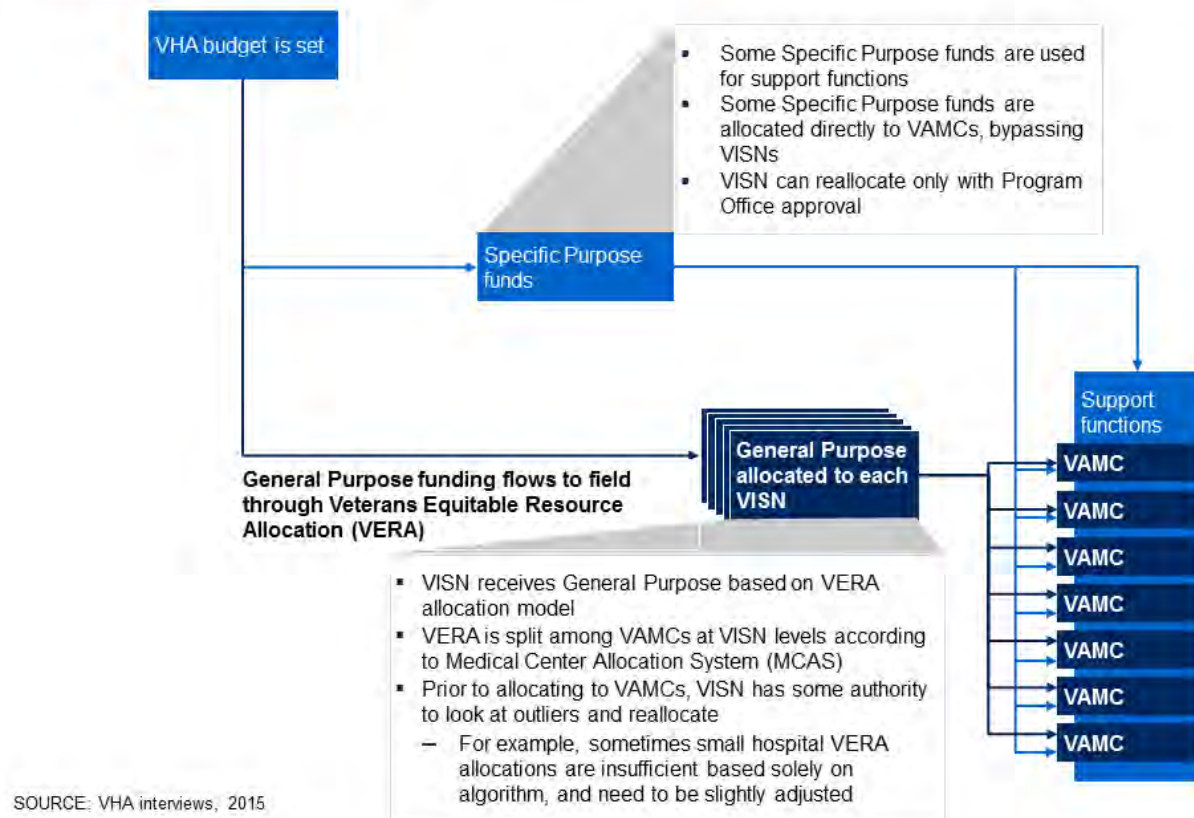
The fragmentation of Specific Purpose funding also poses a challenge for operators. Specific Purpose funding for FY2015 is spread across more than 450 line items (VHA Finance Office, 2015).

Specific Purpose funds typically flow directly to facilities, bypassing VISNs, which reduces the VISN's role in optimally managing the Network's total resources. **Figure 13-4** offers a high-level overview of how funding flows to the field.

Figure 13-4. Resource Allocation Across VAMCs

Illustrative VHA resource allocation process

ILLUSTRATIVE



13.3 Human Resources – Recruiting

13.3.1 Human Resources Has Not Been Able to Meet the Recruiting Requirements of the VAMCs and VISNs

VHA has large hiring requirements, hiring tens of thousands employees annually – many with specialized clinical expertise. Although a comprehensive examination of the human resources function was not within scope of Assessment L, systematic HR challenges were identified through the course of our assessment. While each of the elements addresses some aspects of the VHA human resources function, one aspect that is not addressed specifically, but surfaced in many places as a critical challenge, is recruiting. Hiring is also cited in VHA’s Blueprint for Excellence as a critical challenge that VHA is facing, and as of May 2015 “Reducing hiring barriers” status was rated as “potential risk (yellow)” (VHA, Blueprint for Excellence, 2014). This assessment did not conduct an end-to-end review of the hiring process, but our initial findings suggest significant challenges with the current system and indicate an end-to-end review could be worthwhile.

For many reasons, HR has not been able to meet the recruiting requirements of the VAMCs and VISNs. Recruiting is crippled due to the length of process and cumbersome systems that do not “talk” to each another and are not user-friendly. The length of time to hire priority positions stretches for months, and the process is not user-friendly to applicants. HR is expected to fill a position within 60 calendar days, 80 percent of the time, but process requirements, even if perfectly executed, take about 49 to 62 days [Figure 13-5].

Figure 13-5. Hiring Process

HR is expected to fill a position within 60 calendar days 80% of the time, but process requirements, even if perfectly executed, takes ~50-60 days

ILLUSTRATIVE

	Number of business days	Number of calendar days	Responsible	
Job announcement	5-14 (14 if bargaining unit position)	7-20	Supervisor and HR Specialist	Insights from the field <ul style="list-style-type: none"> “Measures for recruiting / hiring are unrealistic when you consider the process requirements” “On a perfect day (with nothing going wrong), we’re already at the 60 day target” “Yet most Medical Centers and VISNs will say that they’re meeting their hiring targets of ‘60 calendar days, 80% of the time’” “But we know that things aren’t that perfect, so this reporting is not accurate”
Qualification	5	7		
Review, interview, and selection	25	35	Service Chiefs	
Offer made	2	--	HR	
	37-45	49-62		

SOURCE: VHA interviews, 2015

Business leaders and HR personnel alike express frustration around recruiting.

Business leaders express:

- “You end up playing games, instead of ‘hiring like the rest of the world’ and selecting the best applicants.”
- “We lose people in the process – it takes three months to onboard and they receive other offers in the meantime.”
- “The last MD I hired in Mental Health took 200 days beginning to end. They’re looking at other offers. We lost an NP and an MD because of the long wait.”
- “The hiring process is completely broken.”

And HR personnel concur:

- “We’re supposed to fill 80 percent of positions within 60 days. If I follow all the rules and everything goes perfectly – we have the candidates, others do what they’re supposed to do – it takes 58 days. It’s nearly impossible to hit this because of all the hoops we have to jump through.”
- “I don’t know who is responsible for filling Quadrad roles.”

Candidates also express dissatisfaction over the recruiting experience. For example, we spoke with multiple Quadrad leaders who had interviewed for Medical Center Director positions more than two months earlier, and had either not yet heard from anyone regarding the outcome, or had heard through other avenues (such as the local newspaper) that the position had been filled.

It should be noted that the HR recruiting function must operate in an incredibly complex environment, making a difficult task even harder. Federal rules and regulations create many distortions and make effective HR delivery much more challenging than the private sector (for example, OPM guidelines and Veterans’ Preference). Operating multiple systems that do not interface seamlessly leads to inefficiency. One HR administrator observed: “We have 39 HRIS²⁴ systems, and they don’t talk to each other. We don’t all have to use all of them, but we all have to use 20 or more no matter what piece of the HR job we do.” This systematic fragmentation and limited system interoperability exacerbate challenges associated with scale, structure, staffing, training, and process. VAMC, VISN, VHACO, VACO, and other federal entities (such as OPM) each “own” part of the HR process. Finally, Central Office, VISN, and VAMC policies are added to OPM policies, increasing the complexity.

Fixing recruiting, and thereby the hiring process, will not be simple; however, it is imperative to maintain the health of VHA’s own workforce.

²⁴ Human resource information systems

Appendix A Detailed Methodology

To ensure a broad range of sources, our assessment draws upon national datasets, national surveys, expert interviews, and visits to selected VAMCs across the country at which we conducted interviews. These are listed in the bibliography.

A.1 Interviews

Upon defining each of the eight elements, the Assessment L team developed a set of key questions around each element that formed the backbone of our Assessment L interviews. The key questions for each element are laid out below in **Appendix Table A-1**.

Appendix Table A-1. Key Interview Questions

Element from Veterans Choice Act Legislation	Assessment L Interview Questions
Culture	<ul style="list-style-type: none"> How would you define the culture here? How does leadership influence the culture?
Accountability	<ul style="list-style-type: none"> How are leaders held accountable? How should leaders be held accountable? To what degree do you feel you have the authority to successfully perform your roles and responsibilities? How do Central Office directives or guidelines influence or impact leadership decisions and execution?
Reform Readiness	<ul style="list-style-type: none"> How ready are your leaders to drive large-scale changes/ transformation efforts for your organization? What are the biggest barriers to change that you face as a leader?
Leadership Development	<ul style="list-style-type: none"> Have you attended any leadership development programs? What has left an impression with you? How do you select participants for leadership development programs in general – both formal and informal? How do you measure the effectiveness of these programs – both formal and informal?
Physician Alignment	<ul style="list-style-type: none"> Describe the relationship between physicians and the administration here. How are physicians involved in larger facility-wide decision-making? How about when a specific problem arises?
Employee Engagement	<ul style="list-style-type: none"> Describe for us how engaged employees are right now? Has this changed over time? How are issues identified, raised, and resolved here?

Element from Veterans Choice Act Legislation	Assessment L Interview Questions
Succession Planning	<ul style="list-style-type: none"> How are leaders identified at VHA? What are the leadership characteristics you tend to see in VHA's future leaders? Are there other characteristics that are needed but you don't see as often? What's the state of the leadership pipeline? Tell me about the last time a key staff member or colleague left the organization – how did you approach filling the position? How long did it take?
Performance Management	<ul style="list-style-type: none"> How are the performance metrics captured at the facility level used to make management decisions? On individual performance management, what happens after the formal evaluation cycle is complete, with what frequency are leaders giving feedback to and reviewing important metrics with employees?

Appendix Table A-2 presents the distribution of the interviews conducted.

Appendix Table A-2. Distribution of Interviews

Location	Pentad / Non-Pentad	Number of Interviews
VAMC	Pentad	95
	Non-Pentad	129
VISN	Pentad	34
	Non-Pentad	12
VHACO, VACO		30
Other federal agencies and former VHA leaders		10
Total		310

A.2 VAMC Site Selection

To increase consistency and generalizability of findings, teams have coordinated our sampling methods to the extent possible while ensuring the sampling methodology reflected assessment-specific considerations. We selected a core set of VAMCs to visit, which are representative of the VAMC system as a whole across critical facility demographic and performance outcome metrics.

The VAMC site selection process followed the following steps:

- 1. Stratification of facilities.** Stratified random sampling, with VISN as strata, was used to select an initial long-list of facilities. To reduce sample size, a subset of VISNs was randomly selected, from which one of the two initially selected sites was randomly de-selected.
- 2. Review of distribution.** Chi-square testing was used on each of the key facility profile and performance variables to ensure the distribution of scores in the sample is representative of the population. Variables were chosen to reflect anticipated drivers of facility performance, and included: VISN, rurality, adjusted admissions, complexity level (on VHA rating scale), adjusted LOS, patient satisfaction, cumulative access score, and facility age.
- 3. Refinement of facility selection.** Initial facility list was vetted with internal and external SMEs and augmented as needed, to include facilities that are considered critical for inclusion (for example, a Polytrauma Center, facilities with innovative tools/practice) and ensure that all selected facilities had the range of services being assessed.

This method resulted in a sample of 23 facilities and is representative across each of the criteria used in selection.

A.2.1 VAMC Site Selection Variables

Variables were selected based on criteria relevant to each assessment area and assumed impact on facility performance. Variable definitions are given below:

- **VISN.** Used VHA Support Center (VSSC) classification of VAMCs by VISN.
- **Rurality.** Used VSSC 2014 categorization of facilities as rural or urban.
- **Adjusted admissions.** Relied upon American Hospital Association (AHA) 2014 data. Adjusted admissions = Total admissions* (Admissions*[OP revenues/total revenues]) VHA reports revenue data (gross billed revenue) to AHA to calculate this metric. Adjusted admissions scores were divided into quartiles, with the middle quartiles grouped, to produce low (<2881.75), medium (2881.75-6081.00), and high (>6081.00) adjusted admissions categories.
- **Complexity level.** Used VSSC 2014 categorization of facility complexity. Level 1 facilities were grouped, to produce selection criteria of high complexity (Levels 1a, 1b, and 1c), medium complexity (Level 2), and low complexity (Level 3).
- **Adjusted LOS.** Used VA SAIL data. As only Q3 FY2014 was available to us at the time of selection, we were only able to use that quarter's results. Length of Stay (LOS) data were divided into quartiles, with the middle quartiles grouped, producing three variables: low LOS (<4.19), medium LOS (4.19-5.14), and high LOS (>5.14).
- **Patient satisfaction.** Used VA SAIL data. As noted above, as only Q3 FY2014 was available to us at the time of selection, only that quarter's results could be used. Patient satisfaction data were divided into quartiles, with the middle quartiles grouped, resulting in low (<249.83), medium (249.83- 264.02), and high (>264.02) satisfaction categories.

- **Cumulative access score.** Used VA SAIL data. As noted above, as only Q3 FY2014 was available to us at the time of selection, only that quarter's results could be used. The eight access scores included in the VA Q3 FY2014 SAIL report were assigned quartiles and added together to produce a single cumulative access score, which was then divided into quartiles. This process resulted in cumulative score quartile categories of low (<17), medium-low (17-20), medium-high (20-23), and high (>23) access.
- **Facility age.** Relied upon VSSC 2014 operational date data for each VAMC. Operational dates were divided into quartiles, with the middle two quartiles grouped, producing categories of early (prior to June 4, 1929), medium (June 4, 1929, to April 7, 1952), and recent (after April 7, 1952) establishments.

In several instances, variable data were not available for each VAMC. To ensure that these cases were not excluded from the sample, the team scored absences with -1 and included the -1 score as a category for each selection criterion where there were absences.

A.2.2 VAMC Core Site Selection Representativeness

Results for Fisher's Exact Test demonstrate that the sample is not significantly different from the population of VAMCs.

Appendix Table A-3. Fishers Exact Test Results

numerical_complexity_level_variable (p-value for Fisher's Exact Test: 0.80)					
	Population	% Pop	Selected	% Selected	Difference
-1	2	1%	0	0%	-1%
1	88	59%	16	70%	11%
2	32	21%	4	17%	-4%
3	28	19%	3	13%	-6%
Total	150	100%	23	100%	
rurality_numerical_variable (p-value for Fisher's Exact Test: 1.0)					
	Population	% Pop	Selected	% Selected	Difference
0	28	19%	4	17%	-1%
1	122	81%	19	83%	1%
Total	150	100%	23	100%	
adjusted_admissions_quartile (p-value for Fisher's Exact Test: 0.74)					
	Population	% Pop	Selected	% Selected	Difference
-1	22	15%	2	9%	-6%
1	32	21%	5	22%	0%
2	64	43%	9	39%	-4%

Assessment L (Leadership)

3	32	21%	7	30%	9%
Total	150	100%	23	100%	
adjusted_los_quartile (p-value for Fisher's Exact Test: 0.68)					
	Population	% Pop	Selected	% Selected	Difference
-1	39	26%	4	17%	-9%
1	28	19%	3	13%	-6%
2	55	37%	11	48%	11%
3	28	19%	5	22%	3%
Total	150	100%	23	100%	
adjusted_patient_satisfaction_quartile (p-value for Fisher's Exact Test: 0.83)					
	Population	% Pop	Selected	% Selected	Difference
-1	39	26%	4	17%	-9%
1	28	19%	5	22%	3%
2	55	37%	9	39%	2%
3	28	19%	5	22%	3%
Total	150	100%	23	100%	
cumulative_access_score_quartile (p-value for Fisher's Exact Test: 0.78)					
	Population	% Pop	Selected	% Selected	Difference
-1	32	21%	3	13%	-8%
1	33	22%	7	30%	8%
2	27	18%	4	17%	-1%
3	33	22%	4	17%	-5%
4	25	17%	5	22%	5%
Total	150	100%	23	100%	
operational_date_quartile (p-value for Fisher's Exact Test: 0.87)					
	Population	% Pop	Selected	% Selected	Difference
1	38	25%	5	22%	-4%
2	74	49%	11	48%	-2%
3	38	25%	7	30%	5%
Total	150	100%	23	100%	

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A.3 VISN Site Selection

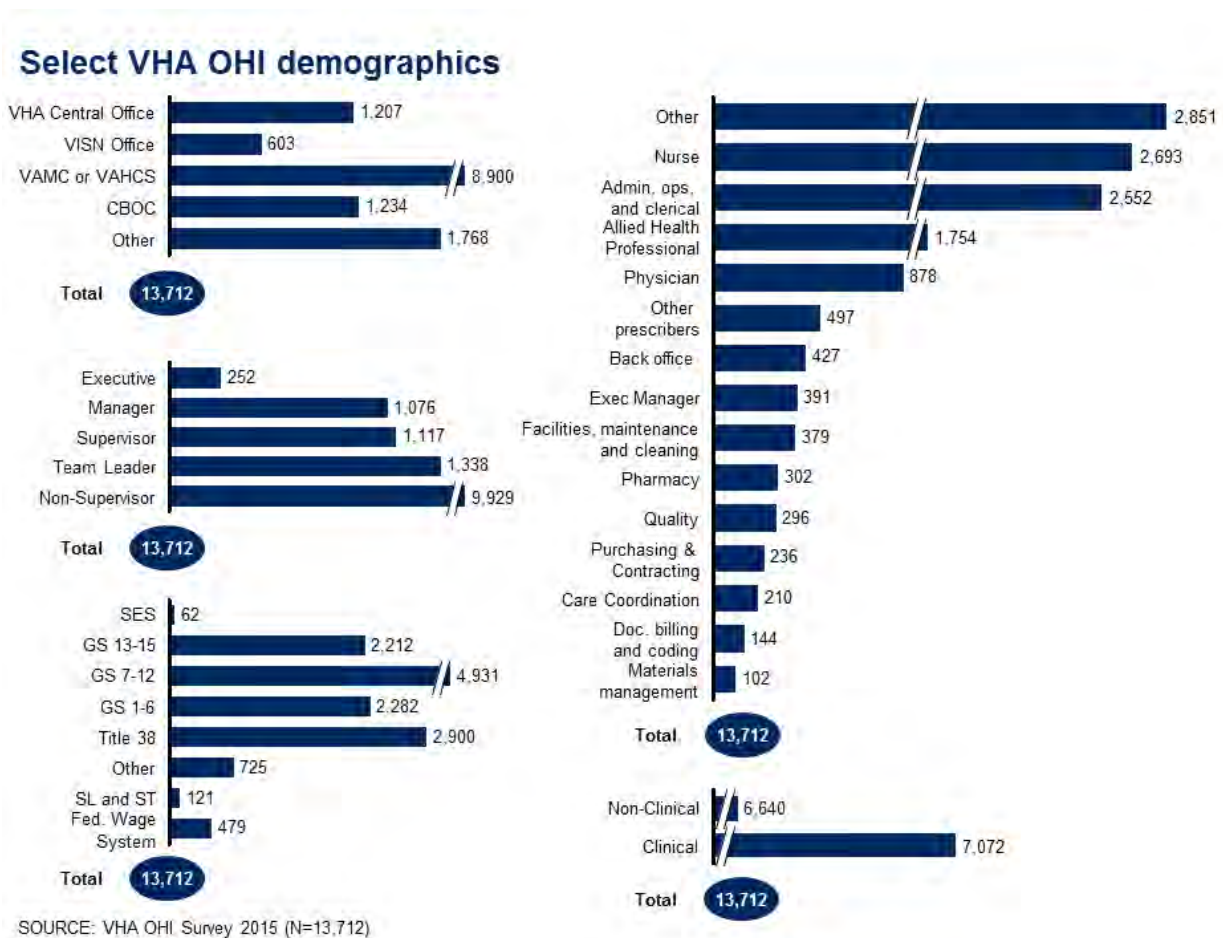
In addition to the VAMCs described above, the Assessment L team also selected sample VISN headquarters to visit, as well as three additional VAMCs. The VISN leadership is seen as an important part of the chain of command with distinct duties that significantly impact VAMC leadership. The Assessment L team visited 13 of the 21 VISNs. Given the relative homogeneity of the VISNs (in comparison to the VAMCs), the need to be as efficient with resources as possible, within limited time, we selected VISN sites that were in geographic proximity to the VAMCs selected. The VISN sites did not influence which VAMCs were selected.

A.4 Organizational Health Index Supporting Data

The OHI was one of the major instruments used to conduct the assessment of VHA leadership. The Methodology Section describes the basis of the OHI and the statistical tests used to validate its results. The OHI Survey was launched as a census survey on March 18, 2015 and stayed open through April 17, 2015. The communication effort included an initial memo from Dr. Clancy, Former Interim Under Secretary for Health, and additional communications from VISN and VAMC leadership. A detailed data cube has been provided to VHA.

The OHI results are based on a statistically valid sample. The participation was n=13,712, with a response rate of five percent. Select demographics are laid out in **Appendix Figure A-1**.

Appendix Figure A-1. Select VHA OHI Demographics



The OHI standard calculates margin of error at the 95 percent confidence level, which means that there is a 95 percent probability that the results of the complete population are within the margins of error of the results obtained. It is a standard used across the industry. The average margin of error was VHA: +/- 0.82 percent.

These results were validated against the other instruments and techniques used during the assessment.

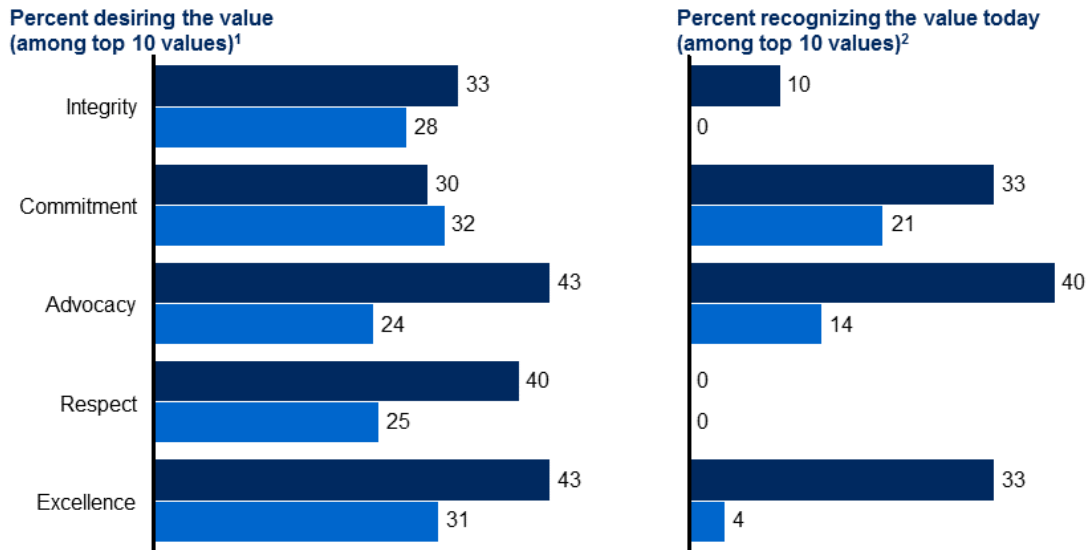
Several additional analyses based on OHI data are presented below. **Appendix Figure A-2** below shows how the different levels in the organization rank order the ICARE values. SES felt that ICARE values were prevalent in today's organization at a much higher rate than all of the other grade categories, with Respect being the one value that all ranks felt was not among the top 10 values today.

Appendix Figure A-2. ICARE values

Current and desired ICARE value mapping on the OHI by grade

Employees at VAMCs and CBOCs (N = 9,199)

■ SES (N=30)
■ GS 1-15 & Title 38 (N=9,169)



¹ Specific language of question reads: "Please select a minimum of 5 and a maximum of 10 statements from this list of values that best describe your views regarding what VHA's culture should be like in the future. Please also choose a minimum of 5 and a maximum of 10 statements that least describe your views regarding what VHA's culture should be like in the future"

² Specific language of question reads: "Please select a minimum of 5 and a maximum of 10 statements from this list of values that best describe VHA currently. Please also choose a minimum of 5 and a maximum of 10 statements that least describe VHA currently"

SOURCE: VHA OHI Survey 2015 – VAMC & VAHcS & CBOC (N=9,199)

Appendix Figure A-3 below shows the full set of values (not just ICARE) and how the different grades viewed their prevalence today. SES viewed Veteran focus as the most prevalent value, while GS 13-15 and Title 38 employees ranked bureaucracy as the most prevalent value. This same group also ranked slow-moving and silos much higher in prevalence than the SES employees.

Appendix Figure A-3. Value Mapping Varies by Demographics (1 of 3)

Today's values seen differently by level of employment

Value mapping on the OHI: Current

Percent employees recognizing the value today; VAMCs and CBOCs only

- 40%+ (Highest)
- 20-39%
- 10-19%
- 0-9% (Lowest)
- Point of interest

Respondents	SES N=30	GS 13-15 N=1,338	GS 7-12 N=3,792	GS 1-6 N=1,578	Title 38 N=2,461
Veteran focus	73	51	46	37	41
Bureaucracy	40	57	40	25	52
Being of service to others	33	36	34	34	31
Internal politics	17	30	29	19	36
Having a noble purpose	53	36	26	19	24
Slow-moving	10	34	26	15	32
Hierarchical	23	32	24	17	32
Caring	30	22	24	24	20
Commitment	33	25	22	22	18
Inconsistent	0	17	16	12	23
Silos	0	22	13	1	22
Advocacy	40	13	15	15	14
Making a difference	20	12	11	10	8
Contributing to the greater good	13	11	9	8	6
Conflict	0	7	8	6	17

■ General agreement across grades on Veteran focus and bureaucracy

■ More senior employees have slightly more positive view (e.g., a higher percent recognize having a noble purpose and advocacy)

SOURCE: 2015 VHA OHI; VAMC & VAHcS & CBOC (N=9,199)

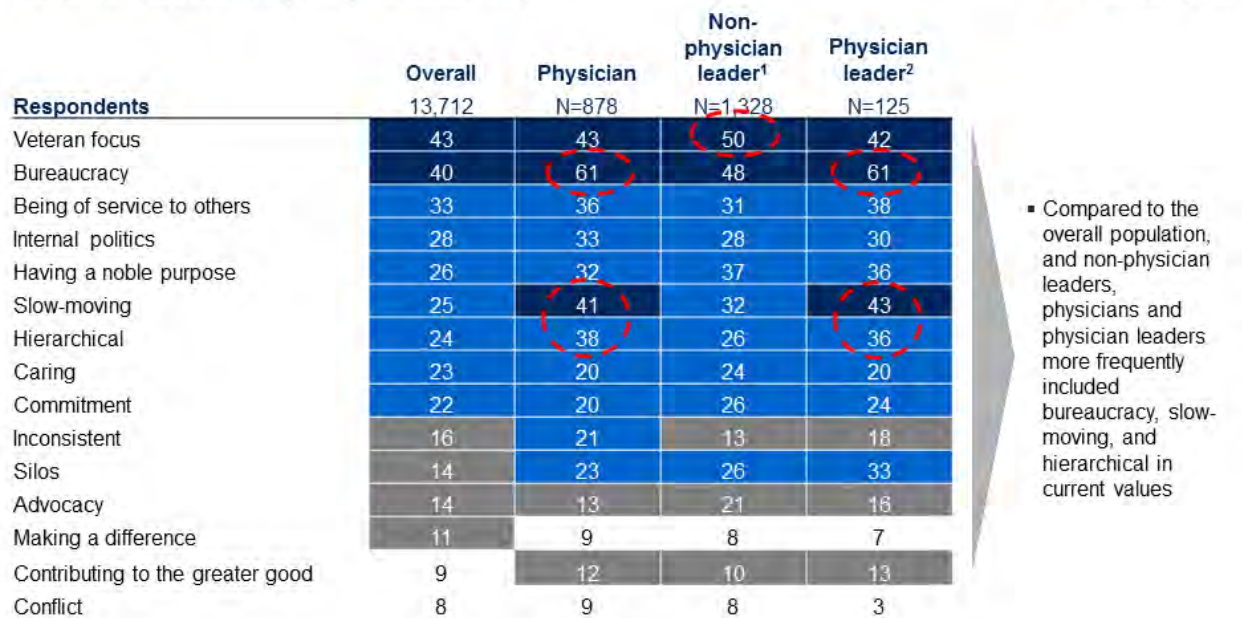
Appendix Figure A-4 below shows the full set of values (not just ICARE) and how they differed in ranking between physicians and non-physicians. Physicians (leaders and non-leaders) felt bureaucracy was the most prevalent value today, while non-Physicians felt Veteran focus was the number one value, followed closely by bureaucracy.

Appendix Figure A-4. Value Mapping Varies by Demographics (2 of 3)

Today's values seen differently by VHA physicians, non-physician leaders, and physician leaders

Value mapping on the OHI: Current

Percent employees recognizing the value today



¹ Executives or managers who do not identify as physicians

² Respondents who identified as physician and executive or manager

SOURCE: VHA OHI Survey 2015 (N=13,712)

Appendix Figure A-5 below shows the full set of values (not just ICARE) and how the different grades viewed their desired level of prevalence. The results are roughly similar across

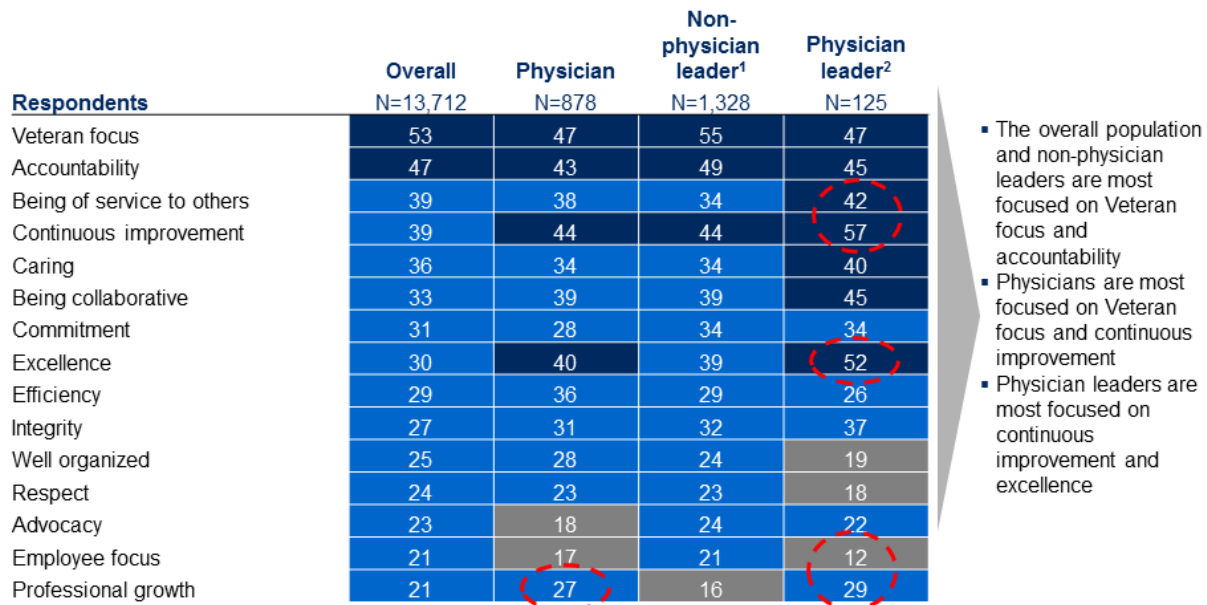
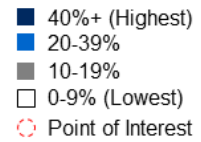
physicians and non-physicians, except for professional growth which was valued much higher by physicians.

Appendix Figure A-5. Value Mapping Varies by Demographics (3 of 3)

Desired values seen differently by VHA physicians, non-physician leaders, and physician leaders

Value mapping on the OHI: desired

Percent of employees desiring the value



¹ Executives or managers who do not identify as physicians

² Respondents who identified as physician and executive or manager

SOURCE: VHA OHI Survey 2015 (N=13,712)

A.5 Approach to Recommendation Development

Assessment L's considerable breadth, combined with the sense of urgency presented by the current environment, present the context for our recommendations. Each element, and therefore each finding, is interrelated with others. It follows, then, that opportunities to improve VHA cannot be approached in isolation, but rather in thoughtful coordination; our recommendations draw upon findings and themes that cross multiple elements and were considered as a whole during development.

In considering the findings collectively, inspiration was found through private sector practices, pockets of existing practices within VHA, and past experience with companies facing similar difficulties. We undertook an iterative process combining two approaches – a bottom-up approach using each element to generate recommendations and identify several themes – followed by a top-down approach to spur additional ideas within these identified themes. Throughout this process, various drafts were also refined with internal experts with significant expertise in government innovation, hospital operations, and broader private sector

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experience, and the Blue Ribbon Panel established by MITRE as part of this assessment. Recognizing that change efforts will be designed to both address and incorporate multiple elements (such as, culture, accountability, and performance management), the recommendations are presented across elements rather than element-by-element.

Four guiding principles supported the development of these recommendations:

1. **Bold.** As detailed above, the scale of challenges requires bold action. Some of the recommendations laid out may be provocative: we offer them in the belief that they are necessary, and to do less will not be sufficient.
2. **Feasible.** The recommendations should strike a balance between boldness and practicality, recognizing the current operating environment in which this change needs to occur – a system that needs to be stabilized.
3. **Clear.** The recommendations themselves should be simple and easy to understand by a broad range of stakeholders. Given the complexity of the interdependencies between them, this simplicity is critical.
4. **Detailed.** The recommendations should be detailed enough to offer a sense of how they could become actionable. The team stops short of implementation-ready detail, however, as that is better developed by change leaders and owners. The recommendations also need to be detailed enough such that one can say “yes” or “no” to them.

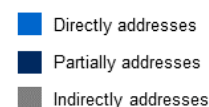
A.6 Validation: Mapping Findings to Recommendations

As explained in Section 2.1 Validation and Testing, after analyzing and synthesizing data, we developed a set of detailed recommendations to address findings. We then analyzed these recommendations to determine their relevance and importance to the findings.

To ensure comprehensive coverage, we mapped the seven overall findings against the six overall recommendations to create a “heat map” of coverage. Overall recommendations were considered against each overall finding and assigned a score of relevance. All overall findings were, at minimum, directly addressed by one overall recommendation and indirectly addressed by another. This analysis is shown below in **Appendix Figure A-6**.

Appendix Figure A-6. Mapping Overall Findings to Overall Recommendations

Mapping overall findings to overall recommendations



Overall findings	Overall recommendations					
	1. Clarify strategic direction	2. Stabilize, grow, and empower leaders	3. Redesign VHA's operating model	4. Focus and simplify performance management	5. Rebuild a high-performing, healthy culture	6. Redesign the human resources function
1. Confusion around leadership priorities and the strategic direction of VHA						
2. The VHA organization is intensely, unnecessarily complex due to lack of a clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities						
3. The broader VHA culture is characterized by risk-aversion and distrust						
4. VHA leadership faces a workforce that appears to be steadily losing its motivation						
5. The performance of a particular VAMC hinges to a large degree on the capability of its Director and the executive leadership team; yet they are "on their own" in many ways						
6. VHA leadership attention is consumed by addressing crises that have occurred in the past, at the expense of preparing for tomorrow's opportunities						
7. The leadership pipeline is not robust enough to meet VHA's current and future needs						

Through similar processes, we also conducted a detailed mapping exercise. A detailed findings by detailed recommendations map was created to determine the coverage. In this analysis, we grouped detailed findings by their corresponding category of assessment, as done in Sections 5 – 12. Section 13, Support Infrastructure, was also analyzed. Each detailed recommendation was then assigned a value of relevance corresponding to detailed findings. This check showed comprehensive coverage and relevance across all findings and recommendations, consistent with the analysis of the overall mapping shown above.

A.7 Review of Past Reports

The team conducted a literature review of past reports of VHA leadership and identified reports that directly addressed one or more of the eight elements within scope of Assessment L (e.g. OIG and GAO). Below is the list of reports reviewed as well as summaries of findings and recommendations from them [Figure Appendix A-7 and A-8]. These reports were used to provide context for Assessment L; however, all analyses in this report are based on primary source data.

- Booz Allen Hamilton. (Jul. 2008). Final Report on the Patient Scheduling and Waiting Times Measurement Improvement Study.

- Northern Virginia Technology Council (NVTC). (Aug. 2014). Opportunities to Improve the Scheduling of Medical Exams for America's Veterans: A Report Based on a Review of VA's Scheduling Practices. Retrieved from: <http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf>
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- U.S. Department of Veterans Affairs. Office of the Inspector General. (May 2014). Interim Report - Review Patient Wait Times, and Scheduling Practices, and Alleged Patient Deaths at the Phoenix VA Health Care System. Retrieved from: <http://www.va.gov/oig/pubs/VAOIG-14-02603-267.pdf>
- U.S. Department of Veterans Affairs. Office of the Inspector General. (Aug. 2014). Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System. Retrieved from: <http://www.va.gov/oig/pubs/VAOIG-14-02603-267.pdf>
- U.S. Government Accountability Office. (Feb. 2015). GAO High Risk Series: An Update, 2015. Retrieved from: <http://www.gao.gov/products/GAO-15-290>
- U.S. Government Accountability Office. (2005). Human Capital: Selected Agencies Have Opportunities to Enhance Existing Succession Planning and Management Efforts, GAO-05-585. Retrieved from: <http://www.gao.gov/assets/250/246964.pdf>

Appendix Figure A-7. Recent Studies Correspond With Our Assessment

Recent studies in the last decade have identified many of the same issues identified in our assessment (1/2)

Identified in study

Category	Issues cited	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Leadership development and succession planning	The current approach to training and developing leaders is inadequate and should be fundamentally revamped												GAO ²
	There are opportunities to coordinate and share training and development programs across federal agencies		GAO ⁵										
	Program planning is limited									OIG ¹			
	VHA can report on program participation and cost, but could better develop identifying outcome-oriented measures		GAO ⁵										
	VHA has identified gaps in occupations or competencies, and has undertaken strategies to address these gaps		GAO ⁵										
	Succession planning has support and commitment from top leadership, and high-level positions are directly accountable		GAO ⁵										
Culture and employee engagement	A culture of innovation is needed to move VHA forward					BAH ³							
	Leadership plays a significant role in shaping culture					BAH ³							
	The role and importance of leadership to health care performance and transformation is critical and overarching					BAH ³							
	Inadequate documentation of retention incentives awards and lack of guidance, oversight, and training								OIG ¹				
Accountability	Leadership is not held accountable for results, even when they were aware of problems											OIG ¹	GAO ²
	Inadequate oversight and accountability												GAO ²
	Inconsistent compliance / implementation of policies, processes, procedures, and practices											OIG ¹	GAO ²
	No timely resolution of problems and recommendations											OIG ¹	GAO ²

1 VA Office of the Inspector General, "VHA: Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System," 2014

2 GAO High Risk Series: An Update, 2015

3 Booz Allen Hamilton: "VA: Final Report on Patient Scheduling and Waiting Times Measurement Improvement Study," 2008

4 NVTG, "Opportunities to Improve the Scheduling of Medical Exams for America's Veterans: A Report Based On a Review of VA's Scheduling Practices," 2014

5 GAO, GAO, "Human Capital: Selected Agencies Have Opportunities to Enhance Existing Succession Planning and Management Efforts (05-585)," 2005

6 VA OIG, "VA OIG Audit of Retention Incentives for Veterans Health Administration and Veterans Affairs Central Office," 2011

7 VA OIG, "VA OIG Audit of ADVANCE and the Corporate Senior Executive Management Office Human Capital Programs," 2012

Recent studies in the last decade have identified many of the same issues identified in our assessment (2/2)

Identified in study

Category	Issues cited	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Performance management	Self-assessments and self-reported data is inconsistent, inaccurate, and sometimes misleading											OIG ¹	
	Gaps in the availability of data required by VA to efficiently identify resource needs and to ensure that resources are effectively allocated												GAO ²
	Incorrect processes impact validity of data, some of which are considered for awards and salary increases											OIG ¹	
	VHA can report on program participation and cost, but could better develop identifying outcome-oriented measures												
Reform readiness	Lack of clarity exists around strategic objectives, which makes setting and achieving goals difficult					BAH ³							
	VA faces unique challenges in scaling change across an enterprise of its size											NVTC ⁴	
Other: systems and processes	Systems are cumbersome and don't always "talk" to one another											OIG ¹	
	Lack of oversight in adherence to process and systems protocols											OIG ¹	
	Staff violated system protocol, and in some cases were instructed to do so											OIG ¹	
	Executives and senior staff were aware that staff were using inappropriate scheduling practices											OIG ¹	
	Leaders taught staff to use inappropriate scheduling practices and/or did not fully communicate about scheduling best practices												
Other: HR	Increasing availability and efficiency of human resources could have a high impact on timeliness of care					BAH ³							GAO ²

1 VA Office of the Inspector General, "VHA: Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System," 2014

2 GAO High Risk Series: An Update, 2015

3 Booz Allen Hamilton: "VA: Final Report on Patient Scheduling and Waiting Times Measurement Improvement Study," 2008

4 NVTC, "Opportunities to Improve the Scheduling of Medical Exams for America's Veterans: A Report Based On a Review of VA's Scheduling Practices," 2014

5 GAO, GAO, "Human Capital: Selected Agencies Have Opportunities to Enhance Existing Succession Planning and Management Efforts (05-585)," 2005

6 VA OIG, "VA OIG Audit of Retention Incentives for Veterans Health Administration and Veterans Affairs Central Office," 2011

7 VA OIG, "VA OIG Audit of ADVANCE and the Corporate Senior Executive Management Office Human Capital Programs," 2012

Appendix Figure A-8. Recommendations to Respond to Issues

Recent studies have laid out a suite of recommendations to respond to issues identified (1/2)

■ Identified in study

Category	Issues cited	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Leadership development and succession planning	Give leaders broad exposure to leaders in other realms					BAH ³							
	VA should consider alternative but complementary approaches to assessing leaders					BAH ³							
	Leaders should be rewarded for efforts that spur innovation					BAH ³							
	Clearly define desired leadership competencies					BAH ³							
	Improve training												GAO ²
	Improve impact measures of programming									OIG ⁷			
	Enhance financial incentive programs to attract and retain top talent					BAH ³							
	VA should proactively analyze and prepare for changing demands and staffing needs (for example, specialty MDs)					BAH ³							
	VHA should seek opportunities to coordinate succession planning and development programs with other agencies								OIG ⁶				
	Conduct 100 percent reviews of retention incentives and stop unnecessary payments.								OIG ⁶				
Culture and employee engagement	Build a culture of innovation and build leadership development model to support it					BAH ³							
	Engage frontline staff in the change process					BAH ³							
	Conduct reviews of internal and external best practices					BAH ³							

1 VA Office of the Inspector General, "VHA: Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System," 2014

2 GAO High Risk Series: An Update, 2015

3 Booz Allen Hamilton: "VA: Final Report on Patient Scheduling and Waiting Times Measurement Improvement Study," 2008

4 NVTG, "Opportunities to Improve the Scheduling of Medical Exams for America's Veterans: A Report Based On a Review of VA's Scheduling Practices," 2014

5 GAO, GAO, "Human Capital: Selected Agencies Have Opportunities to Enhance Existing Succession Planning and Management Efforts (05-585)," 2005

6 VA OIG, "VA OIG Audit of Retention Incentives for Veterans Health Administration and Veterans Affairs Central Office," 2011

7 VA OIG, "VA OIG Audit of ADVANCE and the Corporate Senior Executive Management Office Human Capital Programs," 2012

Recent studies have laid out a suite of recommendations to respond to issues identified (2/2)

Identified in study

Category	Issues cited	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Accountability	Hold VHA leaders accountable for VHA action plans					BAH ³						OIG ¹	
	Hold VHA leaders accountable for their individual assessment plans					BAH ³							
	Clarify existing policies												GAO ²
Performance management	Standardize management dashboards					BAH ³							GAO ²
	Management decisions should be made on reliable and complete data											NVTC ⁴	
Reform readiness	VA should engage frontline staff in the process of change											OIG ¹	
Other: HR, systems and Processes	Establish internal mechanisms to perform quality assurance reviews of scheduling accuracy											OIG ¹	
	Redesign the recruitment process and consider possibility of outsourcing it					BAH ³							

1 VA Office of the Inspector General, "VHA: Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System," 2014

2 GAO High Risk Series: An Update, 2015

3 Booz Allen Hamilton: "VA: Final Report on Patient Scheduling and Waiting Times Measurement Improvement Study," 2008

4 NVTC, "Opportunities to Improve the Scheduling of Medical Exams for America's Veterans: A Report Based On a Review of VA's Scheduling Practices," 2014

5 GAO, GAO, "Human Capital: Selected Agencies Have Opportunities to Enhance Existing Succession Planning and Management Efforts (05-585)," 2005

6 VA OIG, "VA OIG Audit of Retention Incentives for Veterans Health Administration and Veterans Affairs Central Office," 2011

7 VA OIG, "VA OIG Audit of ADVANCE and the Corporate Senior Executive Management Office Human Capital Programs," 2012

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Appendix C Acronyms

ADUSHOM	Assistant Deputy Under Secretary for Health of Operations and Management
AES	All Employee Survey
AHA	American Hospital Association
ALOS	Average Length of Stay
BLS	Bureau of Labor Statistics
CABG	Coronary Artery Bypass Surgery
CAMH	CMS Alliance to Modernize Healthcare
CBOC	Community-Based Outpatient Clinics
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CPRS	Computer Patient Record System
CSEMO	Corporate Senior Executive Management Office
DUSHOM	Deputy Under Secretary for Health of Operations and Management
ECQ	Executive Core Qualification
EBITDA	Earnings before interest, taxes, depreciation, and amortization
EEO	Equal Employment Opportunity
FEVS	Federal Employee Viewpoint Survey
FFRDC	Federally Funded Research and Development Center
FFY	Federal Fiscal Year
FTE	Full Time Equivalent
FY	Fiscal Year
GAO	Government Accountability Office
GS	General Schedule
HCLDP	Health Care Leadership Development Program
HR	Human Resources
HRIS	Human Resource Information Systems
ICARE	VA's core values, including Integrity, Commitment, Advocacy, Respect, Excellence
IG	Inspector General

IOC	Independent Outpatient Clinic
IRS	Internal Revenue Service
IT	Information Technology
LOS	Length of Stay
MCAS	Medical Center Allocation System
MD	Medical Doctor
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSPB	Merit System Principle Board
NCA	National Cemetery Administration
NExT	New Executive Training Program
NP	Nurse Practitioner
NRM	Non-Recurring Maintenance
OHI	Organizational Health Index
OIG	Office of Inspector General
OMB	Office of Management and Budget
OPM	Office of Personnel Management
P&T	Pharmacy & Therapeutics
PACT	Patient Aligned Care Team
PBM	Pharmacy Benefits Management
PMA CAP	President's Management Agenda Cross-Agency Priority
R&D	Research and Development
RIF	Reduction in Force
RN	Registered Nurse
ROI	Return on Investment
RRA	Reform and Restructuring Act
RVU	Relative Value Unit
SAIL	Strategic Analytics for Improvement and Learning
SCIP	Strategic Capital Investment Plan
SES	Senior Executive Service
SME	Subject Matter Expert
USC	U.S. Code

VA	Veterans Affairs
VACO	Veterans Affairs Central Office
VALU	VA Learning University
VAMC	Veterans Affairs Medical Center
VBA	Veterans Benefits Administration
VERA	Veterans Equitable Resource Allocation
VHA	Veterans Health Administration
VHACO	Veterans Health Administration Central Office
VISN	Veterans Integrated Service Network
VSSC	VHA Support Service Center

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